

**HHS INSPECTOR GENERAL'S AUDIT OF THE
HCFA'S FY 1997 FINANCIAL STATEMENTS**

HEARING
BEFORE THE
SUBCOMMITTEES ON HEALTH AND ENVIRONMENT
AND
OVERSIGHT AND INVESTIGATIONS
OF THE
COMMITTEE ON COMMERCE
AND THE
SUBCOMMITTEE ON GOVERNMENT MANAGEMENT,
INFORMATION, AND TECHNOLOGY
OF THE
COMMITTEE ON GOVERNMENT REFORM
AND OVERSIGHT
HOUSE OF REPRESENTATIVES
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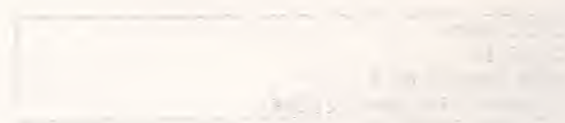
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CONTENTS

	Page
Testimony of:	
Brown, Hon. June Gibbs, Inspector General, Department of Health and Human Services; accompanied by Joseph E. Vengrin, Assistant Inspector General for Audit Operations and Financial Statement Activities	11
DeParle, Hon. Nancy-Ann Min, Administrator, Health Care Financing Administration	56
Material submitted for the record by:	
DeParle, Hon. Nancy-Ann Min, Administrator, Health Care Financing Administration, letter dated June 23, 1998, to Hon. Joe Barton, enclosing responses for the record	98
Inspector General, Department of Health and Human Services, responses to Questions of Hon. Steve Horn	99

HHS INSPECTOR GENERAL'S AUDIT OF THE HCFA's FY 1997 FINANCIAL STATEMENTS

FRIDAY, APRIL 24, 1998

HOUSE OF REPRESENTATIVES, COMMITTEE ON COMMERCE,
SUBCOMMITTEE ON HEALTH AND ENVIRONMENT AND
THE SUBCOMMITTEE ON OVERSIGHT AND INVESTIGA-
TIONS, AND THE COMMITTEE ON GOVERNMENT REFORM
AND OVERSIGHT, SUBCOMMITTEE ON GOVERNMENT
MANAGEMENT, INFORMATION, AND TECHNOLOGY,

Washington, DC.

The subcommittees met, pursuant to notice, at 10 a.m., in room 2123, Rayburn House Office Building, Hon. Joe Barton (chairman, Subcommittee on Oversight and Investigations) presiding.

Members present: Representatives Bilirakis, Barton, Horn, Kucinich, Norwood, Greenwood, and Green.

Staff present: Matthew Saylor, majority counsel; Marc Wheat, majority counsel; Chris Knauer, minority counsel; J. Russell George, staff director and chief counsel; Dianne Guensberg, GAO detailee; John Hynes, professional staff member; Matthew Ebert, clerk; Mason Alinger, staff assistant; Kami White, intern; Faith Weiss, minority counsel; Mark Stephenson, minority professional staff member, and Earley Green, minority staff assistant.

Mr. BARTON. The hearing will come to order.

Today we are holding a joint hearing on the Department of Health and Human Service's Office of the Inspector General audit of the Health Care Financing Administration's fiscal year 1997 financial statements. I am pleased to say that this joint hearing is with the Subcommittee on Oversight and Investigations, the Subcommittee on Health and Environment of the House Commerce Committee, as well as, the Subcommittee on Government Management, Information, and Technology of the Committee on Government Reform and Oversight that is so ably chaired by Congressman Horn of California. I want to welcome Congressman Horn and other members of his subcommittee to this important hearing.

I understand that having an audit is not always a pleasant experience, but it is sometimes a necessary evil in disclosing the financial position of an agency and keeping track of where its money is going in hopes of reducing waste and inefficiency. I and many of the members here today know from firsthand experience. As you will recall a few years ago, we had the first ever audit of the House of Representatives. The findings of that audit were a wake-up call that the House needed to improve its efficiency and keep a better watch over our dollars.

When looking at HCFA, the largest component of the Department of Health and Human Services and the agency that is responsible for administering Medicare, a program that accounts for 13 percent of all Federal spending, we are talking about an agency that truly needs to know where its dollars are going and where there may be weaknesses in how those dollars are being spent. With more than 38 million beneficiaries and more than 800 million claims being processed and paid annually, along with volumes and volumes of very complex and confusing reimbursement regulations, the Medicare program is inherently vulnerable to making improper payments. Last year, we found out just how vulnerable the program really was when the HHS Inspector General undertook its first comprehensive financial statement audit of HCFA. The Inspector General's audit, which was released in July 1997, reported a 14 percent error rate in paying fee-for-service claims that amounted to approximately \$23 billion. That is the number that made the headlines and has been used ever since when we talk about waste, fraud and abuse in Medicare.

Today we are going to hear from the Inspector General, who has now completed their second audit of HCFA. This is for the fiscal year 1997. We have a new number, and I am sure that this new number is going to be referred to and quoted throughout the year. This year the Inspector General estimates that improper payments for fiscal year 1997 were \$20.3 billion, or about 11 percent of the total Medicare fee-for-service benefit payments. As the Inspector General will say, though, when she testifies, this is a number that has to be used with caution because it is not attributable solely to waste, fraud and abuse. In fact, the Inspector General has never attempted to quantify what portion of these improper payments are attributable to fraud. Instead, the Inspector General has stated that improper payments could range from inadvertent mistakes to outright fraud and abuse.

I understand that the Inspector General does not know whether we are dealing with outright fraud or mere mistakes. What we do know, however, is that these are taxpayer dollars, and we do know that if the audit is correct, those are dollars that should not have been spent at all whether it was by mistake or because of intentional fraud. We want our health care dollars in Medicare to go to legitimate health care payments for senior citizens.

In addition, while it may sound somewhat encouraging that the Inspector General's point estimate is \$3 billion less than last year's estimate, we cannot conclude, and the Inspector General does not conclude, that the current error rate is statistically different. So we all agree that we still have a long way to go when we are talking about trying to find ways to prevent waste, fraud and abuse.

Also of great concern from last year's audit findings was the fact that due to HCFA's poor accounting system, the Office of Inspector General could not render an opinion on HCFA's financial statements because the documentation was not adequate or available to support the amounts reported in the financial statements. This year, HCFA has improved its accounting system so that the Inspector General can issue a qualified opinion. What this means is that the fiscal year 1997 financial statements were fairly presented, ex-

cept that some problems, which the Inspector General will be describing in the testimony, do still exist.

Again, I would like to say that I believe this audit of HCFA's financial statements provides a valuable tool for the Congress in reviewing the financial status of HCFA and how it spends taxpayers dollars. This subcommittee has, and will continue to work closely with HCFA and the Office of Inspector General in protecting Medicare dollars from being improperly paid out, while trying to preserve the solvency of the Medicare program.

That said, I am pleased that we are going to have the Inspector General with us today, Ms. June Gibbs Brown. I am also pleased that we will hear from the new Administrator of HCFA, Ms. Nancy-Ann Min DeParle. We will be very interested to hear these two people's testimony and their response to this year's findings.

With that, I am going to recognize Mr. Green for an opening statement. He says he is representing three entire subcommittees of the Democratic side of the aisle, and I notice he has now been joined by another member of the Democratic Party, so he is representing half of the three subcommittees. Mr. Green.

Mr. GREEN. Thank you, Mr. Chairman. I am glad my colleague from Ohio joined us today. I have a dozen opening statements that my colleagues have asked me to provide this morning, but I won't read them all, we will just submit them for the record. I thank the chairman for scheduling this hearing today, and since votes were canceled today, I am disappointed that so many members from both sides of the aisle could not participate.

For the second year, the Inspector General's audit of HCFA practices have come up with very disturbing news highlighting that HCFA's controls over the Medicare program need improvement. According to an IG report, HCFA processed and paid \$477.4 billion in processed claims in fiscal year 1997. Approximately 90 percent of those claims, or \$20.3 billion, were spent on questionable or inappropriate claims that should not have been paid.

It is very troubling that in the same year that Congress had to vote to cut billions of dollars in Medicare spending, such a large amount of money was not appropriately accounted for by HCFA. It seems like every time Congress passes health care legislation, we include new and improved provisions to reduce the fraud, waste and abuse; in fact, some of us could say that in our sleep, because of the concern over the last few years. Unfortunately, this latest report indicates that our efforts may not be as much as we had hoped for, although it is a step in the right direction, and hopefully, we can look at the legislation.

Mr. Chairman, I am a new member of the Commerce Committee, but I served before that on Government Reform and Oversight and on the Oversight and Investigations Subcommittee that Congressman Shays was the ranking member of—or the chairman of it, and so I know the frustration of a number of committees in Congress who continue to work on this problem. I am looking forward to the distinguished witnesses to identify the causes of the overpayments and what exactly they represent, and how we can reduce this in the future, and particularly address the percentage, that 11 percent, and how that compares to the private sector of, "waste, fraud

and abuse," or documentation questions and how that relates to that.

So Mr. Chairman, again, thank you. I am glad we are having the hearing, and hopefully we will be able to follow up on this in all of our subcommittees.

Mr. BARTON. I want to thank you, Congressman Green.

I would now recognize the distinguished subcommittee chairman, Mr. Horn from California, for an opening statement.

Mr. HORN. Thank you very much, Chairman Barton and Chairman Bilirakis. I appreciate the opportunity to join you.

We are here today to discuss the status of the financial management practices and information at the Health Care Financing Administration. This is the fifth in a series of hearings that the Government Reform and Oversight Subcommittee on Government Management, Information, and Technology have been involved with, and we are pleased to join in this effort.

Three weeks ago we held a hearing on the first ever government-wide audit on financial statements and financial status. Not since 1789, they had one then, have we had such an audit, and we learned a lot from it. On the 15th, we hit with our first agency, that is the Internal Revenue Service; on the 16th, the Department of Defense where they have had long standing problems in terms of accounting for money in relation to purchase orders. On April 17, we looked at the lessons learned at the Social Security Administration, where they have fairly good practices and management systems. Social Security was the first agency to complete this year's audit. It received a clean opinion on its financial statements for the fourth year in a row. It has an effective system of internal controls and these are commendable achievements.

I am pleased we are having this joint hearing, because the Health Care Financing Administration is tremendously important to at least 50 million Americans and 100 million of their relatives in terms of Medicare and Medicaid. These hearings have raised serious issues affecting the soundness of fundamental management information used by decisionmakers. In the balance are the quality of our governmental services and the fiscal health of the Nation. Congressional attention to financial management, therefore, is crucial.

The amount of money that flows through the Health Care Financing Administration is very large. It is third only to the Bureau of Public Debt and the Social Security Administration in outlays, accounting for 18 percent of the Federal budget, or about \$300 billion. A third of all dollars spent on health care in the United States is paid through the Health Care Financing Administration.

More disturbing, however, is the explosive growth in Medicaid and Medicare. The growth in these programs has far outpaced the growth in the Consumer Price Index, almost 4 times faster than the general Consumer Price Index and more than twice as fast as the Consumer Price Index for medical goods and services. The Congressional Budget Office's projections of the cost of these entitlement programs is very sobering. CBO projects that by the year 2008, the cost of Medicare and Medicaid will grow to \$658.3 billion. In other words, the cost of these programs will more than double over the next decade.

The Inspector General of the Department of Health and Human Services has done much to expose the waste that has been allowed to flourish in the Medicare program and is working, I understand, with more than half the States to expose similar problems in the Medicaid program. It is disturbing to note that the Inspector General's estimate of \$20.3 billion in Medicare waste does not even include fraudulent and abusive schemes that have been perpetrated by unscrupulous individuals in order to exploit the program.

Medicare, and I happened to serve on the drafting committee when it came to the Senate in 1965, is critical to the security of millions of elderly Americans. We cannot afford to continue to waste nearly \$1 out of every \$10 that goes to the program. We need dramatic improvements in the management of the Health Care Financing Administration's programs, and I hope the two key witnesses today can describe how that will be accomplished.

Mr. BARTON. We thank you, Congressman Horn.

We would now like to welcome the ranking member of the Subcommittee on Government Management, Information, and Technology, the former Mayor of Cleveland, Congressman Kucinich.

Mr. KUCINICH. Thank you, Mr. Chairman, members of the committee. It is a pleasure to be here with my colleagues and with the chairman of our committee, Mr. Horn. I would like to welcome the Administrator of HCFA and the Inspector General of HHS, who are here to discuss the results of the 1997 HCFA audit.

In the 1996 audit of HHS, the Inspector General found that the agency's financial information was not reliable, and this year the HCFA audit received a qualified opinion, which means that the Inspector General could determine where the financial accounting vulnerabilities exist. So obviously, this is a step in the right direction. The auditors did raise several concerns which I think the committee is going to be interested in getting into.

I would like to talk for a minute about the Medicare program and what it means to so many Americans. The Medicare program provides health insurance for 38 million elderly and disabled citizens. Without it, many of these Americans would be deprived of adequate health care. That is unacceptable in a wealthy, civilized society. Medicare provides Americans with the security that, as they get older and increasingly more vulnerable to serious and even debilitating medical problems, it assures them they will have access to the best medical care in the world and that medical illness will not bankrupt their families. Receiving a Medicare card is a rite of passage in this country. The card is an affirmation of our concern as a society for the well-being of our citizens. In essence, it reflects that social compact which we have in America that we recognize the responsibility for each other.

We can see Medicare's importance. That is why we need to assure that it runs well. Last year, the Medicare program processed over 800 billion Medicare claims and—is that billion or million—800 billion Medicare claims and paid more than \$200 billion. HCFA is effectively stemming the rise in Medicare spending. Health care spending as a share of the gross domestic product, which has remained constant since 1993.

Now, HCFA's efforts to combat fraud and abuse are impressive. Through Operation Restore Trust, HCFA recouped nearly \$1 billion

in 1997 and cracked down on documented fraud and abuse by home health care, skilled nursing facilities, and durable medical equipment providers nationwide. In 1997, HCFA saved an estimated \$7.5 billion by identifying inappropriate payments through increased medical reviews, audits, and antifraud efforts.

I want to stress that one of the areas that I am concerned about is the decreasing number of medical record reviews that Medicare's private contractors conduct. These contractors should be reviewing medical records regularly. Currently they review only 2 percent of the Medicare claims they receive. These private companies have no economic incentive to conduct more frequent or intensive record reviews unless they get paid per review. This is troubling. And HCFA is searching for alternative mechanisms to fund further medical reviews.

I want to say to the Administrators here today, I look forward to your presentation, and I know that some of the serious problems that have already been identified you are trying to work to resolve, so let's get on with the show. Thanks.

[The prepared statement of Hon. Dennis J. Kucinich follows:]

PREPARED STATEMENT OF HON. DENNIS J. KUCINICH, A REPRESENTATIVE IN
CONGRESS FROM THE STATE OF OHIO

The Subcommittee on Government Management, Information, and Technology has been holding an important series of hearings on Federal financial management. Last week, we reviewed the financial management of the Internal Revenue Service, Department of Defense, and the Social Security Administration. Now we will turn our attention to the Health Care Financing Administration in this joint hearing with two Commerce subcommittees. I would like to thank Chairman Horn for his leadership on these issues and for the statesmanlike manner in which he consistently conducts his hearings. I enjoy the opportunity to work with him.

Congress recognized as early as 1990 with the passage of the Chief Financial Officers Act that the federal government should produce reliable financial information that can be audited. The CFO Act directed 10 Federal agencies to conduct independent financial audits. In 1994, Congress expanded the requirement of an audited financial statements to all 24 major agencies. Today, we have the opportunity to discuss some of the tangible results of this process with the HCFA 1997 financial audit.

I would like to welcome the Administrator of HCFA and the Inspector General of HHS who are here to discuss the results of the 1997 HCFA audit. In the 1996 audit of HHS, the IG found that the agency's financial information was so unreliable that the IG could not draw any conclusions about the agency's financial statements. This year the HCFA audit received a qualified opinion, which means that the IG could determine where HCFA's financial and accounting vulnerabilities exist. This is a step in the right direction. However, the auditors raise several serious concerns, and I look forward to learning how HCFA is addressing them.

I'd like to talk for just a minute about the Medicare program, and what it means to so many Americans. The Medicare program provides health insurance for 38 million elderly or disabled citizens. Without it, many of these Americans would be deprived of adequate medical care—an unacceptable situation for a wealthy civilized society. Medicare provides Americans with the security that, as they get older and increasingly more vulnerable to serious—even debilitating—medical problems, they will have access to the best medical care in the world, and it will not bankrupt them or their families. Receiving your Medicare card is a rite of passage in this country. It's an affirmation of our concern as a society for the wellbeing of our elderly citizens. It is, in essence, part of our compact with each other in our American community.

We can see Medicare's importance. That's why we must also assure that it runs well. Last year, the Medicare program processed over 800 billion Medicare claims and paid more than \$200 billion. HCFA is effectively stemming the rise in Medicare spending. Health care spending as a share of the gross domestic product has remained constant since 1993.

The IG audit estimates the size of Medicare payments that lack adequate supporting documentation or that otherwise fail to meet HCFA's requirements. HCFA has been actively trying to reduce the amount of improper or inappropriate payments made by the Medicare program. This has two aspects: On one hand, HCFA and Medicare providers must work together to decrease sloppy record-keeping and inadvertent noncompliance with documentation requirements. On the other hand, the Medicare program must combat fraud and abuse aggressively. The agency realizes that it must reduce the size of improper or inappropriate Medicare payments, which currently appear to range from 11-14% of all Medicare payments.

HCFA's efforts to combat fraud and abuse are impressive. Through Operation Restore Trust, HCFA recouped nearly \$1 billion in 1997 and cracked down on documented fraud and abuse by home health care, skilled nursing facilities, and durable medical equipment providers nationwide. Also in 1997, HCFA saved an estimated \$7.5 billion by identifying inappropriate payments through increased medical reviews, audits, and anti-fraud efforts.

HCFA opened anti-fraud field offices in Florida and Louisiana. It implemented new regulations to prevent fraud by home health care providers, including requiring large bonds and increased accountability. HCFA doubled its audits of home health care companies and increased claim reviews. The agency also issued new regulations to decrease fraud and abuse by durable medical equipment suppliers.

In 1997, HCFA barred over 2,700 individuals and entities from doing business with Medicare, Medicaid, and other state and federal programs because they engaged in fraud and misconduct (that is a 93% increase from 1996); HHS increased convictions for health care fraud by 20% and pursued over 4,000 civil health care fraud cases, an increase of 61% from 1996. HHS actively sought, and obtained, significant funding for fraud and abuse control activities—\$107 million for 1997 and \$120 million for 1998. Recently, HHS awarded \$3 million in grants to fight Medicare fraud and abuse.

It is clear that HCFA is actively pursuing both enforcement and regulatory options, and I would commend Administrator Min DeParle for HCFA's aggressive efforts to tackle fraud and abuse in the Medicare program and in particular her leadership in this regard.

However, I am concerned with the decreasing number of medical record reviews that Medicare's private contractors conduct. These contractors should be reviewing medical records regularly. Currently, they only review about 2% of the Medicare claims they receive. These private companies have no economic incentives to conduct more frequent or intensive record reviews unless they get paid per review. This is troubling, and HCFA is searching for alternative mechanisms to fund medical record reviews.

The IG audit also indicates that the procedures and practices of HCFA contractors who process Medicare claims prevent HCFA from producing reliable financial information. HCFA cannot fine these contractors or use mechanisms available to other federal agencies to ensure contractor compliance. Many of the most serious problems identified in the financial audit are attributed to Medicare contractors—and HCFA can do little about it short of terminating them.

HCFA also faces obstacles aggressively pursuing its Year 2000 conversion, because it lacks the authority over Medicare contractors to ensure their compliance with Y2K conversion. Medicare contractors can walk away from their Y2K responsibilities by canceling their contracts at the last minute, jeopardizing Medicare payments for services provided to millions of elderly or disabled individuals—and suffer no consequences.

HCFA cannot conduct competitive bidding for medical equipment and non-physician services nationally to control costs, because it lacks legislative authorization. The agency cannot contract with entities other than insurance companies to process Medicare claims, also because of outdated statutory limitations. HCFA should have the ability to hire its own contractors and to fire them without the severe financial, logistical, and operational repercussions that flow from current law.

Mr. BARTON. Thank you, Congressman.

We would now like to hear from the distinguished chairman of the Subcommittee on Health and Environment, one of my mentors on the Commerce Committee, Congressman Bilirakis.

Mr. BILIRAKIS. Thank you, Mr. Chairman. As is true with all of us, even though it is a day when it turns out we don't have any votes, and I know many would like to be on their way home, or be home—

Mr. BARTON. May I be excused, Mr. Chairman?

Mr. BILIRAKIS. We are also pleased that we do have these three subcommittees meeting to hear this testimony. It is certainly very significant. Those of you who have testified before a committee or committees previously know that we quite often don't get too many more Members at any one time. But the lack of Members here today is not an indication of lack of interest, I assure you.

I am sorry to learn from today's written testimony that the very agency charged with financing the health care of millions of Americans did not receive a clean bill of health on its own financial records. This is no surprise inspection. Eight years ago Congress passed, as you know, the Chief Financial Officers Act of 1990 to require of government agencies what publicly traded corporations long have done, and that is prepare financial statements that fully disclose their financial positions and the soundness of their internal financial controls. After nearly 8 years of advance notice and over \$100 billion of claims going out the door, this is what the Inspector General found, and I paraphrase:

The Inspector General is still unable to give HCFA an unqualified opinion, a stamp of quality that every investor in the private enterprise would expect. The Inspector General found that \$1 out of every \$10 is improperly spent by HCFA. Of the \$20.3 billion of improper payments, fully \$9 billion is spent paying alleged costs for which no documentation or insufficient documentation exists. The Inspector General found that HCFA may not be collecting millions of dollars in overpayments for providers. A statistical selection of beneficiaries performed by the Inspector General found that of the 8,048 fee-for-service claims processed for payment 1,907 claims did not comply with Medicare laws and regulations, a failure rate of 23.7 percent.

The amount of money that HCFA spends improperly, \$20.3 billion is certainly staggering. Recently the Subcommittee on Health and Environment held a hearing on the National Institutes of Health and all the important work that it is doing, from the human genome project to cancer research, to make us healthier and to increase our longevity. The NIH has an annual budget of \$13 billion to study all of the ailments afflicting mankind. Today we learn that HCFA improperly spends that amount of money, and more, much more, every year. The entire NIH budget would only last through August with HCFA's spend-out rate and improper payments.

You should have witnessed some of the testimony from the afflicted persons and from their parents. I can assure you there were tears in the eyes of many Members of Congress and in the audience hearing some of those stories, when just a little more money would really expedite and accelerate that research. And then we find this misuse and waste of funds.

I have introduced legislation, H.R. 3563, which we are calling the Biomedical Research Assistance Voluntary Option Act, or the BRAVO Act. This legislation will encourage private contributions for NIH research. We cannot afford to waste valuable taxpayers' dollars at a time when increasing medical research at NIH has become one of Congress' top priorities.

I do want to commend Administrator Min DeParle for her work over the past few months. You don't have an easy job and I know

you are working hard to try to correct these problems. Her commitment has resulted in a solid beginning toward reducing fraud in Medicare and other Federal health programs, but we must all acknowledge that we have a long way to go before we can give HCFA a clean bill of health.

Indeed, this matter is being taken very seriously, as I have already said, by the Congress. Today we have an unprecedented hearing of the Commerce Committee Subcommittee on Health and Environment and the Subcommittee on Oversight and Investigations, as well as our colleagues from the Government Reform and Oversight Committee's Government Management, Information, and Technology Subcommittee. I can assure the Inspector General and the HCFA Administrator and the American taxpayers that we will get some straight answers from HCFA and we will get them on the road to recovery as soon as possible. Again I would particularly like to thank the Inspector General and her staff for bringing this information to light.

Thank you, Mr. Chairman.

Mr. BARTON. Thank you, Chairman Bilirakis.

The gentleman from Ohio wants to correct his opening statement.

Mr. KUCINICH. Yes. I just wanted to correct the record when I said that the Medicare program process, a certain number of claims as 800 million. It won't be processing 800 billion until my generation is on Medicare, so.

Mr. BARTON. It is only three zeros.

Mr. Norwood from Georgia.

Mr. NORWOOD. Thank you, Mr. Chairman. I have been trained very thoroughly by my chairman, Mr. Bilirakis, and so my very lengthy statement will be submitted for the record.

[The prepared statement of Hon. Charlie Norwood follows:]

PREPARED STATEMENT OF HON. CHARLIE NORWOOD, A REPRESENTATIVE IN CONGRESS
FROM THE STATE OF GEORGIA

I would like to begin by saying how much I appreciate the hard work of the Office of the Inspector General in conducting the audit of the HCFA's financial statements. It is always reassuring to see that we are making an effort to eliminate government waste in any sector. I hope that this audit and the Inspector General's findings help to encourage more fiscal responsibility on the part of the HCFA and foster an increased awareness of improper Medicare payments.

As the largest division of the Department of Health and Human Services, HCFA oversees a tremendous budget, thus running the risk of making many improper financial transactions. Like any agency of this size, it necessitates a great degree of scrutiny to prevent waste and encourage sound practices. I trust that the audit conducted by the Inspector General did an excellent job of identifying these improper payments, and helped bring to light other flaws within HCFA that need to be corrected.

According to the audit, the dollar amount of improper payments dropped by about \$3 billion between FY 1996 and FY 1997. I understand that it is too early to draw definite conclusions on the issue. However, the lack of oversight by HCFA, the wide variety of regional carrier interpretation of rule and regulations, and failure of HCFA to ensure consistency results in the implementation of its policies is directly responsible for a great deal of the so called fraud waste and abuse. Congress should support programs to make government more efficient and less wasteful. But in doing so we need to assure that we are equitable in our pursuits. If doctors and other health care providers are to be held to high standards of accountability and documentation without just compensation, so too should HCFA and the regional contractors that implement policy.

What I find most disheartening about this whole process is that so many portions of the report could not be determined with any degree of certainty. The fair presentation of Medicare accounts receivable, the accuracy of Medicaid accounts receivable, and the need for an adjustment to the FY 1997 cost report settlement payments were all in question. In the future I would like to see a plan that helps eliminate these uncertainties and that provides more concrete information. I understand that documentation continues to be a problem, and thus prevents anyone from being completely certain about the findings. This reflects problems within HCFA. We need uniformity and clarity, then maybe this dog can hunt.

I am also very concerned that there are so many potential problems with data security in the HCFA central office. The thought that someone could break into the computer system and alter files is extremely unsettling, and definitely needs to be corrected.

Similarly, HCFA definitely needs to take action to correct the year 2000 problem as that year rapidly approaches. If HCFA does not become compliant our current problems will be dwarfed by the payment errors created with that situation.

Though some of the findings may be troubling, the methods HCFA is using to reduce costs are more troubling. We have to first correct them. This report signifies a step in the right direction in eliminating incorrect Medicare payments, but does so the wrong way. We must continue to improve the accuracy and dependability of health care claims without punishing doctors as scapegoats for problems at HCFA and within the regional carriers.

Mr. BARTON. Thank you. Mr. Greenwood?

Mr. GREENWOOD. I will submit it for the record.

Mr. BARTON. Mr. Greenwood apparently has been trained by his chairman. I didn't realize that, but I appreciate that.

[Additional statement submitted for the record follows:]

PREPARED STATEMENT OF HON. ELIZABETH FURSE, A REPRESENTATIVE IN CONGRESS
FROM THE STATE OF OREGON

I want to thank all my colleagues and our witnesses for taking the time to appear today regarding the HCFA financial audit. In particular, I want to thank Nancy-Ann Min DeParle, HCFA Administrator, for her hard work at that agency. She has been responsive to my inquiries about HCFA's current work on diabetes. We are also lucky to have June Gibbs Brown as Inspector General at HHS. Both women are making extraordinary contributions to our society and I want to publicly recognize them for their efforts.

Like most of my colleagues, it is my sincere hope that the results of today's hearing do not get mischaracterized by our colleagues or members of the media. The work that has been done by the office of Inspector General identifies improper payments. Something that is "improper" is not necessarily waste, fraud, or abuse. In many situations, I am certain the Medicare system worked as it should: a senior who needed health care obtained the necessary covered service. While the provider may have neglected to fill out the proper paperwork—and this should not be condoned—it does not automatically mean that the taxpayers were bilked out of any funds.

The work done at HCFA affects the health-care of millions of Americans. We must use caution when examining the testimony today and using it in our future deliberations. With that in mind, I look forward to hearing the testimony of our witnesses.

Mr. BARTON. We would now like to hear from our witnesses. We have the Honorable June Gibbs Brown, who is the Inspector General for the Department of Health and Human Services, if she would come forward; and we have the Honorable Nancy-Ann Min DeParle, Administrator of the Health Care Financing Administration. Would she please come forward.

If the Honorable Ms. Gibbs Brown would introduce the gentleman who is going to assist her.

Ms. BROWN. With me is Joe Vengrin, who is the person who has the supervisory responsibility over all of the preparation of the financial statement audit.

Mr. BARTON. And what is his official title in the Department.

Mr. VENGRIN. Assistant Inspector General.

Mr. BARTON. Each of you understands that it is the tradition of the Oversight Subcommittee to take all testimony under oath. Are any of you opposed to testifying under oath? You also have the right to be advised by counsel under the rules of the subcommittee and the Constitution of the United States. Do any of you wish to use counsel during your testimony?

[Negative responses.]

Mr. BARTON. Would you please stand and raise your right hand.

[Witnesses sworn.]

Mr. BARTON. We are going to start with you, Ms. Brown, and we ask you to turn the microphone on. There is a little switch there. That was Congressman Green's suggestion, and it is an excellent suggestion, so that we can hear you. We are going to recognize you for such time as you may consume. Mr. Vengrin, are you going to give an opening statement or just answer questions? So we will go from Ms. Brown to Ms. DeParle. So you are recognized for such time as you may consume.

TESTIMONY OF HON. JUNE GIBBS BROWN, INSPECTOR GENERAL, DEPARTMENT OF HEALTH AND HUMAN SERVICES, ACCOMPANIED BY JOSEPH E. VENGRIN, ASSISTANT INSPECTOR GENERAL FOR AUDIT OPERATIONS AND FINANCIAL STATEMENT ACTIVITIES; AND HON. NANCY-ANN MIN DePARLE, ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION

Ms. BROWN. Thank you, Mr. Chairman. I am pleased to report to you on the audit of the Health Care Financing Administration's fiscal year 1997 financial statements. I would like to begin by acknowledging the cooperation and support we received from the Department, from HCFA and from the General Accounting Office. A review of this magnitude and complexity would not have been possible without HCFA's assistance in making available medical review staff of the Medicare contractors and the peer review organizations. We also worked closely with GAO, which is responsible for auditing the consolidated financial statements of the Federal Government.

Let me also add that the financial statement audit process, in and of itself, has been extremely valuable in identifying control weaknesses that directly affect the government's ability to protect our tax dollars. I intend to continue our collaboration with GAO and the department to ensure that identified weaknesses are corrected. My statement today will focus first on our Medicare claim testing, and then on HCFA's financial reporting.

Our review included a statistical selection of 8,048 medical claims from a population of \$177.4 billion in fiscal year 1997 fee-for-service claim expenditures. Payments to providers for 1,907 of these claims did not comply with the Medicare laws and regulation. By projecting these sample results, we estimated that fiscal year 1997 net improper payments totaled about \$20.3 billion nationwide, or about 11 percent of the total Medicare fee-for-service benefit payments. This is the midpoint of the estimated range, at the 95 percent confidence level, of the \$12.1 billion to \$28.4 billion, or about 7 to 16 percent.

While this year's point estimate is \$3 billion less than last year's point estimate of \$23.2 billion, we cannot conclude that the current error rate is statistically different. However, there is persuasive evidence that more medical documentation was obtained this year, which had a substantial effect on reducing the midpoint estimate. There is also evidence that some of the drop is due to the sampling variability. As was the case last year, the improper payments could range from inadvertent mistakes to outright fraud and abuse.

It should be noted that medical personnel examination of patient records detected almost all of the improper payments in our sample. When these claims were submitted for payment to Medicare contractors, they contained no visible errors.

This year's sample results confirm last year's. As noted in my first chart, which is also contained in my written testimony, substantial Medicare improper payments continue to be prevalent in four types of health care providers: physicians, inpatient prospective payment system hospitals, home health agencies, and outpatient hospitals. Specifically, these providers first did not adequately document the bases for their claims; second, billed for services that were not medically necessary; third, billed for higher priced procedure codes than were supported by the beneficiary's medical records; and fourth, billed for services that were not allowed by Medicare.

My second chart shows the types of errors found as a percentage of the total improper payments: First, documentation problems. This was the most pervasive error category, even though Medicare regulations specifically require providers to maintain sufficient documentation to justify diagnosis, admissions and other services. Physician and outpatient services accounted for 52 percent of the documentation discrepancies in 1997 and 47 percent in 1996. A lack of medical necessity was the second highest error category for both years. Inpatient prospective payment system hospitals and home health agency claims accounted for over 60 percent of these errors. In our examination, decisions on medical necessity were made by medical staff who followed their normal claim review procedures to determine whether the medical records supported the claims.

Incorrect coding is the third highest error category. Physician and inpatient PPS hospital claims accounted for over 90 percent of both year's coding errors. For most of the coding errors, medical reviewers determined that the documentation submitted by providers supported a lower reimbursement code.

The final error category is unallowable services. This year, about 73 percent of these errors were attributed to physician claims. Unallowable services are those that Medicare will not reimburse because they do not meet Medicare reimbursement rules and regulations.

In view of the current estimate of \$20.3 billion in improper payment, the Medicare program remains at high risk for payment errors. We want to point out, however, that in response to our prior year's recommendations, HCFA has developed and is aggressively pursuing a corrective action plan to reduce the medical payment error rate. Because too little time has elapsed for HCFA to fully

implement these recommendations and to significantly reduce the error rate, we offer no additional recommendations.

Before discussing HCFA's fiscal year 1997 financial statements, I would like to touch on two pivotal issues which resulted in our disclaimer of opinion last year on the fiscal year 1996 statements. Specifically, we were not able to gather sufficient evidence on the validity and reasonableness of Medicare accounts payable; that is, the amounts HCFA owes to Medicare providers, or of supplementary medical insurance revenue, which represents Part B Medicare premiums.

This year, Mr. Chairman, we are pleased to report that HCFA has revised its methodology for estimating Medicare accounts payable, and our auditors were satisfied with the resulting estimate. Also, we were able to audit the supplementary medical insurance revenue this year by working with GAO and the Social Security Administration Office of Inspector General. As a result, our overall opinion on HCFA's financial statements has advanced from a disclaimer for fiscal year 1996 to a qualification for 1997, a significant improvement in accounting terms.

However, we noted continuing documentation problems. First, we could not determine if the reported \$2.5 billion in Medicare accounts receivable balance; that is, what Medicare providers owe to HCFA, was fairly presented, because contractors did not maintain sufficient documentation to support reported activity and to provide adequate audit trails. Our report also discusses our concern that contractors do not have uniform accounting systems to record, classify, and summarize financial information.

In addition, our qualified opinion relates to cost report settlements, the Medicare process for determining final payments to about 45,000 institutional providers, such as hospitals. While HCFA audited about 5,000 providers, the limited scope of these audits provided little assurance that amounts eventually paid to providers meet Medicare guidelines for reasonableness and appropriateness. Therefore, we were unable to determine what adjustments, if any, were necessary to the \$2.4 billion in cost settlement payments or the impact of such adjustments on the \$5 billion year-end cost settlement estimate.

To briefly summarize, Mr. Chairman, unnecessary or improper benefit payments continue to plague the Medicare program. I am pleased that HCFA and the Department's Chief Financial Officer are aggressively pursuing a corrective action plan to address our concerns.

I would also like to note that we have already begun our audit of HCFA's fiscal year 1998 financial statements. Determining whether HCFA has established an adequate internal control structure for Medicare accounts receivable will receive a very high priority. I appreciate the opportunity to appear before you today, and I welcome your questions.

[The prepared statement of Hon. June Gibbs Brown follows:]

PREPARED STATEMENT OF HON. JUNE GIBBS BROWN, INSPECTOR GENERAL,
DEPARTMENT OF HEALTH AND HUMAN SERVICES

Good morning, Mr. Chairman. I am June Gibbs Brown, Inspector General of the Department of Health and Human Services (HHS), and I am pleased to report to you on our audit of the Health Care Financing Administration's (HCFA) Fiscal Year

(FY) 1997 financial statements. With me today is Joseph E. Vengrin, Assistant Inspector General for Audit Operations and Financial Statement Activities.

This year marks our second comprehensive financial statement audit of HCFA. We undertook this audit as part of our implementation of the Government Management Reform Act of 1994 which requires audited financial statements. The purpose of financial statements is to provide a complete picture of agencies' financial operations, including what they own (assets), what they owe (liabilities), and how they spend taxpayer dollars. The purpose of our audit was to independently evaluate HCFA's statements. The full results of this year's audit are provided in our report which is being released at this hearing. My testimony today will highlight the significant findings.

I would like to begin by acknowledging the cooperation and support we received from the Department, HCFA, and the General Accounting Office (GAO). A review of this magnitude and complexity would not have been possible without HCFA's assistance in making available medical review staff at the Medicare contractors and the peer review organizations. Also, I want to point out that we worked closely with GAO, which is responsible for auditing the consolidated financial statements of the Federal Government. The HCFA is one of the most significant agencies included in these Governmentwide statements.

Let me also add that the financial statement audit process, in and of itself, has been extremely valuable in identifying control weaknesses that directly affect the Government's ability to protect our tax dollars. I intend to continue our collaboration with GAO and the Department to ensure that identified weaknesses are corrected.

My testimony today will focus first on our Medicare claim testing and then on HCFA's financial reporting.

Medicare Claim Testing Overview

The HCFA is the largest single payer of charges for health care goods and services in the world. Like other insurers, Medicare makes payments based on a standard claim form. Providers typically bill Medicare using standard procedure codes without submitting detailed supporting medical records. However, Medicare regulations specifically require providers to retain supporting documentation and to make it available upon request. Because of the high risk in Medicare payments and the dollar impact on the financial statements (i.e., \$177.4 billion in fee-for-service claims in FY 1997), we made a comprehensive review of claim expenditures and supporting medical records.

Our primary objective was to determine whether Medicare benefit payments were made in accordance with Title XVIII of the Social Security Act (Medicare) and implementing regulations. Specifically, we examined whether services were (1) furnished by certified Medicare providers to eligible beneficiaries; (2) reimbursed by Medicare contractors in accordance with Medicare laws and regulations; and (3) medically necessary, accurately coded, and sufficiently documented in the beneficiaries' medical records.

Sample Results

Through detailed medical and audit review of a statistical selection of 600 beneficiaries nationwide with 8,048 fee-for-service claims processed for payment during FY 1997, we found that 1,907 claims did not comply with Medicare laws and regulations. *By projecting these sample results, we estimated that FY 1997 net improper payments totaled about \$20.3 billion nationwide, or about 11 percent of total Medicare fee-for-service benefit payments. This is the mid-point of the estimated range, at the 95 percent confidence level, of \$12.1 billion to \$28.4 billion, or about 7 percent to 16 percent.*

While this year's point estimate is \$3 billion less than last year's point estimate of \$23.2 billion, we cannot conclude that the current error rate is statistically different. However, there is persuasive evidence that more medical documentation was obtained this year, which had a substantial effect on reducing the mid-point estimate. There is also evidence that some of the drop is due to sampling variability. Sampling variability means that this year's results could differ from last year's simply because selecting different claims with different dollar values and errors will inevitably produce a different estimate of improper payments.

Payment errors primarily resulted from provider billings for services that were insufficiently documented, medically unnecessary, incorrectly coded, or noncovered. As was the case last year, the improper payments could range from inadvertent mistakes to outright fraud and abuse. We cannot quantify what portion of the error rate is attributable to fraud.

Through medical record reviews which we coordinated, medical personnel detected almost all of the improper payments in our sample. When these claims were submitted for payment to Medicare contractors, they contained no visible errors. It should be noted that the HCFA contractors' claim processing controls were generally adequate for (1) ensuring beneficiary and provider Medicare eligibility, (2) pricing claims based on information submitted, and (3) ensuring the services as billed were allowable under Medicare rules and regulations. However, these controls were not effective in detecting the types of errors we found.

In view of Medicare's 38 million beneficiaries, 853 million claims processed and paid annually, decentralized operations, and the current estimate of \$20.3 billion in improper payments, we have concluded that the Medicare program remains inherently at high risk for payment errors.

Sampling Methodology

To accomplish our objective, we used a stratified, multistage sample design. The first stage consisted of a selection of 12 contractor quarters during FY 1997 (10 from the first, second, and third quarters and 2 from the fourth quarter). The selection of the contractor quarters was based on probabilities proportional to the FY 1996 Medicare fee-for-service benefit payments. The second stage consisted of a stratified random sample of 50 beneficiaries from each contractor quarter. The resulting sample of 600 beneficiaries produced 8,048 claims valued at \$5.4 million for review. The population from which the sample was drawn represented \$177.4 billion in fee-for-service payments.

We reviewed all claims processed for payment for each selected beneficiary during the 3-month period. Specifically, we used medical review personnel from HCFA's Medicare contractors (fiscal intermediaries and carriers) and peer review organizations (PRO) to assess the medical records and to determine whether the services billed were reasonable, medically necessary, adequately documented, and coded in accordance with Medicare reimbursement rules and regulations.

We contacted each provider in our sample by letter requesting copies of all medical records supporting services billed. In the event that we did not receive a response, we made numerous follow-up contacts by letter, telephone calls, and/or on-site visits. Concurrent with the medical review, we made additional detailed claim reviews, focusing on previously identified improper billing practices, to determine whether (1) the contractor paid, recorded, and reported the claim correctly; (2) the beneficiary and the provider met all Medicare eligibility requirements; (3) the contractor did not make duplicate payments or payments for which another primary insurer should have been responsible (Medicare secondary payer); and (4) all services were subjected to applicable deductible and co-insurance amounts and were priced in accordance with Medicare payment regulations.

Problem Areas

This year's sample results confirm our FY 1996 results. As noted in the chart on the next page, substantial Medicare improper payments continue to be prevalent in four types of health care providers: physician, inpatient prospective payment system (PPS) hospital, home health agency, and outpatient hospital. Specifically, these providers:

- Did not adequately document the basis for their claims or, in some cases, provided no documentation;
- Billed for services that were not medically necessary;
- Billed for higher priced procedure codes than supported by the beneficiaries' medical records; and
- Billed for services that were not allowable by Medicare.

Estimated Improper Payments by Type of Provider in FY 1997

Type of Provider	Dollars in Billions
Physician	5.9
Inpatient PPS Hospital	4.1
Home Health Agency	2.6
Outpatient Hospital	1.9
Subtotal	14.5
Other Types of Providers	5.8
Total	20.3

The next chart shows the types of errors found as a percentage of the total improper payments.

Estimated Improper Payments by Type of Error in FY 1997

Type of Error	Percent of \$20.3 Bil- lion Total
No Documentation	4
No Documentation Due to Investigations	14
Insufficient Documentation	26
Subtotal: Documentation Errors	44
Lack of Medical Necessity	37
Incorrect Coding	15
Noncovered or Unallowable Services	3
Other	1
Total	100

Further details on these error categories follow.

Documentation Problems. Two types of providers, physicians and outpatient services, consistently had the most documentation problems; they accounted for 52 percent of this error category in FY 1997 and 47 percent in FY 1996. Medicare regulation, 42 CFR 482.24(c), specifically requires providers to maintain medical records that contain sufficient documentation to justify diagnoses, admissions, treatments, and continued care. However, documentation problems represented the most pervasive error category in both years' samples.

The overall error category of documentation includes three components: (1) no documentation provided after repeated attempts, (2) no documentation due to extenuating circumstances (under investigation), and (3) insufficient documentation. These three components accounted for about \$9 billion, or 44 percent of the \$20.3 billion in improper payments.

The "no documentation" category dropped from \$3.25 billion for FY 1996 to \$850 million for FY 1997. This reduction, we believe, was attributable to the OIG and HCFA outreach efforts to inform providers of our FY 1996 audit results and aggressive action to obtain requested medical records. In fact, we obtained almost 98 percent of the medical records requested for sample claims for providers that were not under investigation.

With respect to the providers that were under investigation, we were prohibited from requesting medical records. Our sample included 151 claims being investigated by the OIG Office of Investigations and 16 claims being investigated by the Medicare contractors' fraud and abuse units. Because we could not test the validity of these claims, we considered them invalid for determining whether total fee-for-service expenditures were fairly presented. It should be noted that these claims could be valid or erroneous (including fraudulent).

Some examples of documentation problems follow:

- A *hospital outpatient department* was paid \$785 for eight outpatient physical therapy services. Because the hospital's medical records supported only three of the eight visits, the medical reviewers concluded that Medicare had overpaid \$491.
- A *durable medical equipment supplier* received almost \$3,000 for renting an electric hospital bed with pressure pad, as well as wound care supplies. The supplier did not respond to our requests for medical records, and we found that its office, which had a current lease, had been vacated. As a result, we referred the supplier to our Office of Investigations and notified the contractor of our actions.
- A *skilled nursing facility* received \$1,967 for a beneficiary's 19-day stay, but the medical records contained no indication that skilled nursing care had been provided. As a result, the entire payment was denied.

Lack of Medical Necessity. In both years, errors in inpatient hospital and home health agency claims accounted for over 60 percent of this error category. A lack of medical necessity was the second highest error category for both FYs 1996 and 1997.

Decisions on medical necessity were made by the contractor or PRO medical staff using Medicare reimbursement rules and regulations. They followed their normal claim review procedures to determine whether the medical records supported the claims, as illustrated in the examples below:

- A beneficiary who had been hospitalized 5 years earlier was admitted to a *hospital* to increase her strength. Rehabilitation therapies included occupational,

physical, and speech therapies, as well as continuation of routine medications. Based on a review of the medical records, the PRO concluded that the documentation did not support the medical necessity for 37 days (\$38,672) of inpatient hospital care.

- A \$2,915 *home health agency* claim for home care visits, including skilled nursing services, was denied because the skilled services were medically unnecessary. Our interview with the beneficiary determined that he left home daily and therefore did not meet the definition of "homebound" necessary for Medicare coverage of home health services.
- Although an *ambulance service* billed \$7,844 for transporting a beneficiary from a nursing home to a dialysis center, the medical reviewer determined that the beneficiary could have traveled safely by far less expensive means.

Incorrect Coding. Incorrect coding is the third highest error category this year, representing 15 percent of the total improper payments. Over 90 percent of these errors pertained to inpatient hospital and physician claims for both FYs 1996 and 1997.

The medical industry uses a standard coding system to bill Medicare for services provided. For most of the coding errors, the medical review staff determined that the documentation submitted by the providers supported a lower reimbursement code. However, we did find a few instances of downcoding which were offset against identified upcoding situations.

Some examples of incorrect coding follow:

- A *physician* was paid \$162 for providing critical care of an unstable, critically ill patient requiring the constant attendance of the physician in a hospital inpatient setting. According to the medical reviewer, the records submitted by the provider did not support this level of care but rather a noncritical, high-complexity hospital visit valued at \$60. This resulted in a \$102 overpayment.
- A *hospital* was paid \$22,229 for an inpatient's surgical procedure based on the principal and secondary diagnosis codes on the claim. The PRO found that the secondary diagnosis code, which indicated complications, was not supported. The PRO's deletion of this code produced a lesser valued diagnosis related group of \$10,151, resulting in a \$12,078 overpayment.
- An *equipment supplier* was paid \$535 for a gel pressure pad for a beneficiary's mattress. Based on the medical records, the medical reviewer concluded that the supplier had actually provided a pressure pad for a wheelchair, which is reimbursed at \$123. This error resulted in an overpayment of \$412.

Noncovered/Unallowable Services. "Medicare unallowable services" are defined as those that Medicare will not reimburse because the services do not meet Medicare reimbursement rules and regulations. About 73 percent of the errors in this category were attributable to physician claims in FY 1997.

Following are some examples of noncovered or unallowable services:

- A *physician* was paid \$114 for a beneficiary's office visit, electrocardiogram, and various other laboratory tests. Based on the medical records, the reviewer determined that payment should be denied because the services were performed as part of a routine physical examination, which is not covered by Medicare.
- A *podiatrist* was paid a total of \$57 for two claims for providing routine foot care (clipping of toenails). Medicare pays for routine foot care only under limited circumstances, such as for the treatment of infected nails. The medical reviewer concluded that the care provided was routine preventive care, which is not covered, and the claim was denied.

Conclusions and Recommendations: Claim Testing

To obtain Medicare reimbursement, providers are required to retain supporting documentation and make it available upon request. As with last year's results, the majority of the improper claims in our sample did not contain any visible errors. However, a significant portion of the errors we found were attributable to insufficient documentation on the part of providers that claimed payments. We also identified numerous errors for services that were not medically necessary, upcoded to obtain higher Medicare payment than the appropriate code would permit, or non-covered or unallowable.

We acknowledge that too little time has elapsed for HCFA to fully implement our prior year's recommendations and to significantly reduce the error rate. Specifically, we recommended last year that HCFA:

1. Develop a system that objectively and periodically estimates improper payments and disclose the range of such improper payments in its financial statements.
2. Develop a national error rate to focus corrective actions and measure performance in reducing improper payments.

3. Enhance prepayment and postpayment controls by updating computer systems to better detect improper Medicare claims.
4. Direct contractors to expand provider training to further emphasize the need to maintain medical records that contain sufficient documentation and the penalties for not doing so.
5. Direct contractors to make follow-up evaluations of specific procedure codes we identified with high error rates and consider whether identified providers should be placed on prepayment medical review.
6. Ensure that contractors adjust their Medicare accounts for improper payments we identified, initiate recovery from the identified providers, and follow up with the providers to correct deficiencies and to determine whether other systemic problems need to be corrected.

The HCFA generally concurred with these recommendations and has developed a corrective action plan to reduce the Medicare payment error rate to 10 percent by the year 2002. Accordingly, we offer no additional recommendations. We expect that HCFA's testimony today will address the specific corrective actions being taken.

Fiscal Year 1996 Disclaimer Issues

Before discussing HCFA's FY 1997 financial statements, I would like to touch on two pivotal issues resulting in our disclaimer of opinion on the FY 1996 financial statements. Specifically, we were not able to gather sufficient evidence on the validity or reasonableness of:

- *Medicare Accounts Payable.* As of September 30, 1996, reported Medicare accounts payable totaled \$36.1 billion and comprised 71 percent of total liabilities. These payables represented HCFA's estimate of actual or potential claims for services provided to beneficiaries but not paid at the end of the FY. The HCFA did not provide adequate support for this estimate. Additionally, we were unable to determine, through alternative audit procedures, if the September 30, 1996, Medicare accounts payable balance was fairly presented.
- *Supplementary Medical Insurance (SMI) Revenue (Part B Medicare).* The Social Security Administration (SSA) is responsible for withholding premiums from SMI beneficiaries' Social Security checks and for transferring these funds to the SMI trust fund each month. Because the SMI revenue was not audited by SSA and because we lack statutory authority to do this work, we were unable to determine the validity and completeness of the SMI revenue account of \$18.9 billion. Therefore, we could not determine whether the corresponding Federal match of \$61.7 billion was appropriate.

Fiscal Year 1997 Qualification Issues

This year, we are pleased to report that HCFA has revised its methodology for estimating Medicare accounts payable, and our auditors were satisfied as to the reasonableness of the resulting estimate. With respect to the SMI issue, we were able to audit this revenue for FY 1997 by working in coordination with GAO and the SSA's OIG. As a result, our overall opinion on HCFA's financial statements has advanced from a disclaimer for FY 1996 to a qualification for FY 1997. In accounting terms, a disclaimer of opinion means that we were not able to determine whether the financial statements were fairly presented because the documentation was not adequate or available to support the reported amounts. A qualification indicates that we still found documentation problems, as discussed below, but not to the extent that would necessitate a disclaimer:

Medicare/Medicaid Accounts Receivable. Medicare contractors did not maintain adequate documentation to support reported accounts receivable activity and to provide adequate audit trails. As a result, we could not determine if the reported \$2.5 billion Medicare accounts receivable balance was fairly presented. For instance:

- We could not obtain reasonable assurance of the completeness and support for \$266 million in accounts receivable that a contractor reported as transferred to other Medicare contractors during its transition from the Medicare program. In addition, HCFA has been unable to reconcile, through its quarterly contractor financial reports, the \$266 million to the acquiring contractors. Based on our review, procedures were either not established or not followed among HCFA and the contractors to confirm and reconcile the transferred accounts receivable.
- At 9 of the 11 contractors reviewed, we were unable to obtain assurance of the completeness of accounts receivable balances because detailed subsidiary ledgers could not support the balances reported to HCFA. For example, one contractor could not provide subsidiary ledgers for \$21 million of the \$86 million balance reported to HCFA. Another contractor "plugged" the "reclassified/adjusted" amount by almost \$758,000 to reconcile the ending subsidiary balance to the balances reported to HCFA but was unable to explain the variance.

In addition, we were unable to perform sufficient procedures to satisfy ourselves as to the reasonableness of the \$450 million Medicaid accounts receivable balance.

Cost Report Settlements. In FY 1997, of 35,079 provider cost reports received, 33,000 were subjected to desk review. Of that total, just over 5,000 providers were selected for audit. Although HCFA has a cost report audit process, the provider audit function is limited to specific issue areas or cost report line items and covers only a limited number of providers. Due to the limited scope of the contractors' provider audit function, there is little assurance that amounts eventually paid to providers through the final cost report settlement process meet Medicare guidelines for reasonableness and appropriateness. We were unable to extend our procedures to determine what adjustments, if any, were necessary to the FY 1997 cost settlement payments of \$2.4 billion recorded by HCFA or to determine the potential impact of such adjustments on the approximately \$5 billion yearend cost settlement estimate included in Medicare other governmental liabilities.

Conclusion

I appreciate the opportunity to appear before you today and to share our report with you. As demonstrated in our review, unnecessary or improper benefit payments continue to plague the Medicare program. Existing risks are sharply increased by the significant growth in Medicare claims and expenditures. Our review has also demonstrated the need for stronger oversight by HCFA to ensure provider compliance with Medicare reimbursement rules and regulations and the necessity of subjecting additional claims to prepayment and postpayment medical review. I am pleased that HCFA and the Department's Chief Financial Officer are aggressively pursuing a corrective action plan addressing our concerns.

Finally, I would like to note that we have already started our audit work on HCFA's FY 1998 financial statements. As we did in the last 2 years, we will conduct comprehensive fee-for-service claim testing. In addition, we will place a high priority on ensuring that HCFA has established an adequate internal control structure for Medicare accounts receivable activity.

I welcome your questions.

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**



**REPORT ON THE
FINANCIAL STATEMENT AUDIT OF
THE HEALTH CARE FINANCING
ADMINISTRATION
FOR FISCAL YEAR 1997**



JUNE GIBBS BROWN
Inspector General

APRIL 1, 1998
A-17-97-00097

INDEPENDENT AUDITOR'S REPORT
INSPECTOR GENERAL'S REPORT ON THE
HEALTH CARE FINANCING ADMINISTRATION'S
FINANCIAL STATEMENTS FOR FISCAL YEAR 1997

To: Nancy-Ann Min DeParle
Administrator
Health Care Financing Administration

We have audited the accompanying statement of financial position of the Health Care Financing Administration (HCFA) as of September 30, 1997, and statement of operations and changes in net position for the year then ended. These financial statements are the responsibility of HCFA's management and include the accounts of all funds it administers, including the Medicare hospital insurance trust fund, the Medicare supplementary medical insurance trust fund, and Medicaid grants. Our responsibility is to express an opinion on these financial statements based on our audit.

Except as discussed in the following paragraphs, we conducted our audit in accordance with generally accepted auditing standards; *Government Auditing Standards* issued by the Comptroller General of the United States; and Office of Management and Budget (OMB) Bulletin 93-06, *Audit Requirements for Federal Financial Statements*. These standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audit provides a reasonable basis for our opinion.

Medicare/Medicaid Accounts Receivable. Medicare accounts receivable are stated at \$2.5 billion, net of the allowance for uncollectible accounts, at September 30, 1997. Such accounts receivable represent amounts providers owe to HCFA due to overpayments reported by Medicare contractors. Some of the contractors visited were unable to provide subsidiary ledgers and other documentation to support reported accounts receivable activity or to reconcile subsidiary records to amounts reported to HCFA. It was not practical to extend our procedures to enable us to conclude on the Medicare accounts receivable balance or related activity. In addition, estimates of Medicaid accounts receivable, stated at approximately \$450 million and netted against the Federal share of Medicaid accounts payable, were developed through a survey process using unaudited information provided by States to HCFA. Such estimates varied significantly by State and by month and were generally not provided at September 30, 1997, but rather were based on earlier reporting dates. Without consistently prepared survey responses and

trend data to analyze the reasonableness of such estimates, it was not practical to extend our auditing procedures to enable us to conclude on the adequacy of Medicaid estimates.

Cost Report Settlements. Medicare Part A providers are paid interim amounts throughout the year and then file a cost report to reconcile actual costs to the interim payments received. In addition to processing and reporting cost settlements made during the fiscal year (FY), HCFA must develop an estimate for cost reports that have not yet been settled at yearend. Typically these payments will not be settled for up to 2 years. Although HCFA has a cost report process, because of limited resources, the provider audit activity is limited to specific issue areas or cost report line items and covers only a limited number of providers. Due to the limited scope of the contractors' provider audit function, there is little assurance that amounts eventually paid to providers through the final cost report settlement process meet Medicare guidelines for reasonableness and appropriateness. We were unable to extend our procedures to determine what adjustments, if any, were necessary to the FY 1997 cost settlement payments of \$2.4 billion recorded by HCFA or to determine the potential impact of such adjustments on the approximately \$5 billion yearend cost settlement estimate included as a component of the Medicare other governmental liabilities.

As discussed in note 13, HCFA has devised a methodology that subjects all cost reports to an automated uniform desk review process. Based on certain criteria, some providers and/or issues are selected for focused, field, or onsite audits. Due to budget constraints, a limited number of cost reports are audited in any given year. About one-third of these are onsite audits of a sample number of providers that would not ordinarily be subject to audit. These onsite, "cyclical" audits are used to ensure that cost and statistical records support the data shown on the cost report and use a customized audit program. The remaining audits are selected to concentrate audit dollars in areas of risk to the Medicare program and to provide sufficient return for the dollars spent.

In 1997, of 35,079 provider cost reports received, 33,000 were subject to desk review. Of that total, just over 5,000 providers were selected for audit. Dollars disallowed averaged 1.5 percent. This workload consisted of two primary groups: (1) hospitals paid based on prospective payment system (PPS) rates and their provider-based facilities and (2) other facilities paid based on costs incurred. The PPS facilities must submit cost reports if they have provider-based home health agencies, outpatient clinics, or other provider-based facilities paid on a cost basis. These cost reports are used both to validate the PPS rates and to ensure that services paid on a cost basis are properly reimbursed. The disallowance rate on these audits was low—less than 1 percent.

The balance of the audits have a higher disallowance rate because they can be targeted toward provider cost reports that have the highest risk to the Medicare program. Dollars disallowed for all non-PPS facilities averaged 4 percent in FY 1997. However, since the uniform desk review does not currently select those cost reports for audit that do not appear to have a significant potential for disallowance, auditing all cost reports does not appear to be cost beneficial.

As described in note 1, HCFA prepared its financial statements in conformity with the hierarchy of accounting principles and standards approved by the Federal Accounting Standards Advisory Board. The hierarchy is a comprehensive basis of accounting other than generally accepted accounting principles.

In our opinion, except for the effects on the financial statements of adjustments, if any, related to the amounts recorded for Medicare/Medicaid accounts receivable and cost report settlements as a result of the matters noted above, the accompanying financial statements present fairly, in all material respects, HCFA's financial position at September 30, 1997, and the results of operations and changes to net position for the year then ended in accordance with the accounting principles described in note 1 to those financial statements.

Our audit was conducted for the purpose of forming an opinion on the statement of financial position as of September 30, 1997, and related statement of operations and changes in net position for the year then ended. The financial information presented in *HCFA's FY 1997 Financial Report*, including the management overview, is supplemental information required by OMB Bulletin 94-01 and is not a required part of the principal financial statements. We assessed whether this information, and the manner of its presentation, is materially inconsistent with the information, and the manner of its presentation, in HCFA's financial statements. This information, which includes trust fund projections, has not been subjected to audit procedures. Accordingly, we express no opinion on it.

REPORT ON INTERNAL CONTROLS

Except for the matters discussed on pages 1 and 2 of our report on the financial statements, we conducted our audit in accordance with generally accepted auditing standards; *Government Auditing Standards*, issued by the Comptroller General of the United States; and OMB Bulletin 93-06, *Audit Requirements for Federal Financial Statements*. These standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements referred to above are free of material misstatement.

In planning and performing our audit of HCFA's financial statements as of and for the year ended September 30, 1997, we obtained an understanding of internal controls, except controls relating to performance measurement data, to determine our auditing procedures for the purpose of expressing our opinion on the financial statements and to determine whether the internal controls meet the objectives identified below. Our consideration included obtaining an understanding of the significant internal control policies and procedures; assessing the level of control risk relevant to all significant cycles, classes of transactions, or account balances; and, for those significant control policies and procedures that have been properly designed and placed in operation, performing sufficient tests to assess more fully whether the controls are effective and working as designed to determine our auditing procedures for the purpose of expressing our opinion on the financial statements and not to provide an opinion on internal control. Accordingly, we do not express such an opinion.

Because of inherent limitations in any internal control structure, errors or irregularities may occur without detection. Also, projecting any evaluation of the internal control structure to future periods is subject to the risk that procedures may become inadequate if conditions change or if the effectiveness of the design and operation of policies and procedures deteriorates.

The HCFA management is responsible for establishing and maintaining an internal control structure. In fulfilling this responsibility, management makes estimates and judgments of the expected benefits and costs of internal control structure policies and procedures. The objectives of an internal control structure are to provide management with reasonable, but not absolute, assurance that:

- Transactions are properly recorded and accounted for to permit the preparation of reliable financial statements and to maintain accountability over assets;
- Funds, property, and other assets are safeguarded against loss from unauthorized use or disposition; and
- Transactions, including those related to obligations and costs, are executed in compliance with laws and regulations that could have a direct and material effect on the principal financial statements and that OMB, HCFA, or we have identified as being significant for which compliance can be objectively measured and evaluated.

Reportable conditions involve matters coming to our attention relating to significant deficiencies in the design or operation of the internal control structure, that, in our judgment, could adversely affect the entity's ability to record, process, summarize, and report financial data consistent with management's assertions in the financial statements.

Material weaknesses are reportable conditions in which the design or operation of one or more internal control structure elements does not reduce to a relatively low level the risk that errors or irregularities in amounts that would be material in the financial statements may occur and not be detected within a timely period by employees in the normal course of performing their assigned functions.

We noted four internal control weaknesses that we consider to be material weaknesses under standards established by the American Institute of Certified Public Accountants and OMB Bulletin 93-06, as well as three reportable conditions:

INTERNAL CONTROL WEAKNESSES

Material Weaknesses

	Page
① Monitoring National Compliance	5 - 18
② Medicare Other Governmental Liabilities	19 - 20
③ Financial Management Controls	20 - 24
④ Electronic Data Processing Controls (General and Application Control Weaknesses)	24 - 30

Reportable Conditions

① HCFA Regional Office Oversight of Medicare	30 - 32
② Federal Share of Medicaid Accounts Payable and Accounts Receivable	32 - 33
③ HCFA Regional Office Oversight of Medicaid	33

Material weaknesses 2 and 4 were not identified as such by HCFA in the Department of Health and Human Services (HHS) FY 1997 Federal Managers Financial Integrity Act (FMFIA) report. Significant components of each of these material weaknesses were reported in previous Chief Financial Officers (CFO) audit reports and remain uncorrected.

MATERIAL WEAKNESSES

1. Monitoring National Compliance - Medicare Fee-for-Service Error Rate

Our FY 1996 audit of HCFA's financial statements, dated July 17, 1997, disclosed an estimated \$23.2 billion in improper payments, or about 14 percent of the total Medicare fee-for-service payments. Considering the significance of the error rate, we concluded that HCFA's oversight of the Medicare program did not provide reasonable assurance of detecting and preventing improper Medicare payments. This constituted a material weakness which required prompt action by HCFA, including the development of a national error rate and increasing its oversight of Medicare expenditures. While HCFA has begun to implement a corrective action plan, it has not had sufficient time to develop its own process for establishing a national error rate or to significantly reduce the amount of improper payments. It was therefore necessary for the Office of Inspector General (OIG) to perform similar sampling of fee-for-service claims in FY 1997.

FY 1997 Medicare Claim Testing Overview

Through detailed medical and audit review of a statistical selection of 600 beneficiaries nationwide with 8,048 fee-for-service claims processed for payment during FY 1997, we found that 1,907 claims did not comply with Medicare laws and regulations. By projecting these sample results, we estimated that FY 1997 net overpayments totaled about \$20.3 billion

nationwide, or about 11 percent of total Medicare fee-for-service benefit payments. The estimated range of the improper payments at the 95 percent confidence level is \$12.1 billion to \$28.4 billion, or about 7 percent to 16 percent. These improper payments primarily resulted from provider billings for services that were medically unnecessary, insufficiently documented, noncovered, or incorrectly coded. As was the case last year, these improper payments could range from inadvertent mistakes to outright fraud and abuse. We cannot quantify what portion of the error rate is attributable to fraud. Specifically, 98 percent of the improper payments in our sample were detected through medical record reviews coordinated by the OIG in conjunction with medical personnel. When these claims were submitted for payment to Medicare contractors, they contained no visible errors. It should be noted that the HCFA contractors' claims processing controls were generally adequate for (1) ensuring beneficiary and provider Medicare eligibility, (2) pricing claims based on information submitted, and (3) ensuring the services as billed were allowable under Medicare rules and regulations. However, these controls were not effective in detecting the types of errors discussed on page 9.

While this year's point estimate is \$3 billion less than last year's point estimate \$23.2 billion, we cannot conclude that the current error rate is statistically different. The difference may be due to sampling variability or HCFA's and the OIG's efforts toward obtaining better documentation. The year's results could differ from last year's because selecting different claims with different dollar values and errors will inevitably produce a different estimate of improper payments.

In view of Medicare's 38 million beneficiaries, 853 million claims processed and paid annually, complex reimbursement rules, decentralized operations, and the current estimate of \$20.3 billion in improper payments, the Medicare program remains inherently at high risk for payment errors. Therefore, HCFA needs to continue its efforts to reduce improper payments.

Audit Objective

Our primary objective was to determine whether Medicare benefit payments were made in accordance with the provisions of Title XVIII and implementing regulations in 42 Code of Federal Regulations (CFR) for services that were:

- Furnished by certified Medicare providers to eligible beneficiaries;
- Reimbursed by Medicare contractors in accordance with Medicare laws and regulations; and
- Medically necessary, accurately coded, and sufficiently documented in the beneficiaries' medical records.

Audit Methodology

Statistical Selection Method. To accomplish our objective, we used a stratified, multistage sample design. Our sample frame consisted of 220 quarters (55 contractors x 4 quarters). We stratified the contractors into two strata: stratum 1 included the first, second, and third quarters, and stratum 2 included the fourth quarter. Selecting two contractors from the fourth quarter controlled the amount of audit work required to review fourth quarter claims. We did not stratify the contractor quarters for FY 1996. The selection within each stratum was based on probability-proportional-to-size using Rao, Hartley, Cochran methodology. We used FY 1996 Medicare fee-for-service benefit payments as the selection weighting factors. Ten contractor quarters were selected from stratum 1, and two contractor quarters from stratum 2. The 12 contractor quarters included 11 contractors (1 contractor was included twice). Of the 11 contractors, 5 are both fiscal intermediaries (FI) and carriers; 2 are FIs, carriers, and durable medical equipment regional carriers (DMERC); 2 are FIs; and 2 are carriers. The FIs process payments for hospitals, skilled nursing facilities (SNF), home health agencies (HHA), rural health clinics, hospices, end stage renal disease facilities, and other institutional providers. Carriers process payments for physicians, clinical laboratories, free-standing ambulatory surgical centers, and other noninstitutional providers. The DMERCs process all claims from suppliers of durable medical equipment (DME), prosthetics, orthotics, and supplies under the Medicare Part B program except those for items incident to physician services in rural health clinics or included in payments to such providers as hospitals, SNFs, and HHAs. A DMERC's claims processing jurisdiction is based on the beneficiary's State of permanent residence.

The second stage consisted of a random sample of 50 beneficiaries from each contractor quarter stratified into 4 strata by total amount of payments for services. The random sample of 600 beneficiaries produced 8,048 claims valued at \$5.4 million for review. To ensure the completeness of the claims data, we reconciled Medicare contractor claims data to the HCFA 1522 Monthly Financial Report for the 12 contractor quarters selected. The HCFA used this report in its preparation of the FY 1997 financial statements.

We used a variable appraisal program to estimate the dollar impact of improper payments in the total population. The population represented \$177.4 billion in fee-for-service payments.

Audit Procedures. We reviewed all claims processed for payment for each selected beneficiary during the 3-month period. Specifically, we used medical review personnel from HCFA's Medicare contractors and peer review organizations (PRO) to assess the medical records and to determine whether the services billed were reasonable, medically necessary, adequately documented, and coded correctly in accordance with Medicare reimbursement rules and regulations.

We contacted each provider in our sample by letter requesting copies of all medical records supporting services billed. In the event that we did not receive a response from our initial letter, we made numerous follow-up contacts by letter and, in most instances, by telephone calls. At

selected providers, we made onsite visits to collect requested documentation. Throughout the medical review, we coordinated OIG and medical review efforts to ensure consistency and accuracy. Concurrent with the medical review, we made additional detailed claims reviews, focusing on past improper billing practices, to determine whether:

- the contractor paid, recorded, and reported the claim correctly;
- the beneficiary and the provider met all Medicare eligibility requirements;
- the contractor did not make duplicate payments or payments for which another primary insurer should have been responsible (Medicare secondary payer (MSP)); and
- all services were subjected to applicable deductible and co-insurance amounts and were priced in accordance with Medicare payment regulations.

Results of Review

Our review confirmed prior findings that the Medicare program is inherently vulnerable to incorrect provider billing practices. Through detailed medical and audit reviews of a statistical selection of 600 beneficiaries nationwide with 8,048 fee-for-service claims processed for payment during FY 1997, we found 1,907 claims that did not comply with Medicare laws and regulations. The contractors have disallowed and already recovered many of the overpayments identified in our sample, consistent with their normal claims adjudication process.

We estimate that the point estimate dollar value of improper Medicare benefit payments made during FY 1997 was \$20.3 billion, or about 11 percent of the \$177.4 billion in processed fee-for-service payments reported by HCFA. The estimated range of the improper payments at the 95 percent confidence level is \$12.1 billion to \$28.4 billion, or about 7 percent to 16 percent. While this year's point estimate is \$3 billion less than last year's point estimate \$23.2 billion, we cannot conclude that the current error rate is statistically different. The difference may be due to sampling variability or HCFA's and the OIG's efforts toward obtaining better documentation. The year's results could differ from last year's because selecting different claims with different dollar values and errors will inevitably produce a different estimate of improper payments.

The following table shows the types of errors and provider claims included in our \$20.3 billion improper payment estimate for FY 1997. About 87 percent of these improper payments occurred within the first six provider types highlighted on the following page:

Types of Errors (dollars in millions)

Type of Provider	Lack of medical necessity	Insufficient documentation	Incorrect coding	Documents not provided due to extenuating circumstances ¹	No documentation	Non-covered or not allowable	All other errors	Total	Percentage of improper payments ²
Physician	\$376	\$2,415	\$1,698	560	\$178	\$387	\$291	\$5,905	29.11%
Inpatient PPS	2,319	460	1,001	264		17		4,061	20.02%
HHA	2,484	68				1		2,553	12.59%
Outpatient	435	1,478	8		2	32	2	1,957	9.65%
DME	100	80	218	1,009	498	33	1	1,939	9.56%
Transportation	397	3	8	714	18	2	(1) ³	1,141	5.63%
Subtotal	\$6,111	\$4,504	\$2,933	\$2,547	\$696	\$472	\$293	\$17,556	86.56%
SNF	471	145				13		629	3.10%
Hospice	329	154			138			621	3.06%
End Stage Renal Disease		81	4	375				460	2.27%
Inpatient Non-PPS	448							448	2.21%
Laboratory	76	230	23	19	16	45	10	419	2.07%
Ambulatory Surgery	45	89	15					149	.73%
Total	\$7,480	\$5,203	\$2,975	\$2,941	\$850	\$530	\$303	\$20,282 ⁴	100.00%
Percentage of Improper Payments	36.88%	25.65%	14.67%	14.50%	4.20%	2.61%	1.49%		

¹ Cases in which the providers were under investigation, and we were prohibited from requesting medical records. Because we could not test the validity of these claims, we considered them invalid for determining whether total fee-for-service expenditures were fairly presented. It should be noted these claims could be valid or erroneous (including fraudulent).

² Percentage of the overall estimate of \$20.282 billion by the type of claim.

³ Negative dollars represent claims for which the number of services billed was less than the number of services provided.

⁴ The range of improper payments at the 95 percent confidence level is \$12.129 billion to \$28.434 billion. Each dollar estimate is computed consistent with the sampling methodology. The sum of all dollars equals the overall estimate of \$20.282 billion.

Each dollar estimate in the previous chart was computed using a method similar to that used in projecting the overall dollar error rate. However, the precision of the dollar estimate by specific type of claim and type of error is not sufficient to use for benchmarking purposes. This would have required an expenditure of audit resources outside the scope of a financial statement audit.

As noted in the chart on the following page, a comparison of the FYs 1996 and 1997 sample results demonstrated that over 70 percent of our point estimate of improper payments in both years occurred in four provider types: physician, inpatient prospective payment system, home health agency, and outpatient services. The chart also shows that most of the errors in both years' samples fell into four general categories:

- ☛ documentation errors, including insufficient documentation, documents not provided due to extenuating circumstances, and no documentation;
- ☛ lack of medical necessity;
- ☛ incorrect coding; and
- ☛ noncovered/unallowable services.

**Comparison of FYs 1996 and 1997 Types of Provider Categories
Highest Estimated Dollars in Improper Payments**

Type of Provider	1997		1996	
	Estimated Dollars in Improper Payments (in millions)	Improper Payments as a Percent of Total	Estimated Dollars in Improper Payments (in millions)	Improper Payments as a Percent of Total
1 Physician	\$5,905	29.11%	\$5,027	21.67%
Documentation	3,153	15.55%	2,756	11.88%
Medically unnecessary/noncovered	763	3.76%	943	4.07%
Incorrectly coded	1,698	8.37%	1,070	4.61%
Remaining errors	291	1.43%	258	1.11%
2 Inpatient PPS	4,061	20.02%	5,239	22.59%
Documentation	724	3.57%	1,040	4.49%
Medically unnecessary/noncovered	2,336	11.52%	3,301	14.23%
Incorrectly coded	1,001	4.93%	900	3.88%
Remaining errors			(2)	-0.01%
3 Home Health Agency	2,553	12.59%	3,650	15.74%
Documentation	68	0.34%	1,684	7.26%
Medically unnecessary/noncovered	2,485	12.25%	1,935	8.34%
Remaining errors			31	0.14%
4 Outpatient	1,957	9.65%	2,810	12.12%
Documentation	1,480	7.30%	2,286	9.86%
Medically unnecessary/noncovered	467	2.30%	441	1.90%
Incorrectly coded	8	0.04%	1	0.01%
Remaining errors	2	0.01%	82	0.35%
Subtotal	14,476	71.37%	16,726	72.12%
5 Other Types of Providers	5,806	28.63%	6,466	27.88%
Documentation	3,569	17.60%	3,080	13.28%
Medically unnecessary/noncovered	1,959	9.66%	3,128	13.49%
Incorrectly coded	268	1.32%	7	0.03%
Remaining errors	10	0.05%	251	1.08%
Total	\$20,282	100.00%	\$23,192	100.00%

Problems with documentation, medical necessity, and coding errors are consistently systemic problems noted in both fiscal years. Details on these matters follow:

☛ Documentation

Medicare regulation, 42 CFR 482.24(c), specifically requires providers to maintain medical records that contain sufficient documentation to justify diagnoses, admissions, treatments performed, and continued care. However, documentation problems represented the most pervasive error category in our sample. This was the largest problem noted in our FY 1996 audit as well. Physician and outpatient services accounted for 52 percent of this error category in FY 1997 and 47 percent in FY 1996.

The overall error category of documentation includes three components: (1) insufficient documentation, (2) no documentation due to extenuating circumstances (under investigation), and (3) no documentation provided after repeated attempts. These three components accounted for about \$9 billion (\$5.203 billion for insufficient documentation, \$2.941 billion for documents not provided due to extenuating circumstances, and \$850 million for no documentation), or about 44 percent of the \$20.3 billion in improper payments.

The no documentation category was \$3.250 billion for FY 1996 and \$850 million for FY 1997. There was clearly a reduction in this error category due to the OIG and HCFA outreach efforts to inform providers of our FY 1996 audit results and aggressive action to obtain requested medical records. We obtained almost 98 percent of the medical records requested for sample claims for providers that were not under investigation. As a result of last year's audit, HCFA hosted informational meetings with major provider professional organizations representing various physician specialties, the home health care industry, the DME industry, skilled nursing facilities, chiropractors, hospitals, and other providers. The purpose of these meetings was to familiarize the organizations with our findings and to explore opportunities for collaborating on educational efforts. As a result, various organizations agreed to publicize our audit findings and documentation guidelines in newsletters and other materials issued to their members.

As previously indicated, if providers failed to furnish supporting medical records or submitted insufficient records after the initial request, the reviewers generally requested such documentation numerous times before determining the payment to be improper. In addition, we made repeated contacts with certain providers and even visited some to collect the requested documentation.

With respect to the extenuating circumstances component, these are cases in which the providers were under investigation, and we were prohibited from requesting medical records. Specifically, our sample included 151 claims being investigated by the OIG Office of Investigations and 16 claims being investigated by the Medicare contractors' fraud and abuse units. Because we could not test the validity of these claims, we considered them invalid for determining whether total

fee-for-service expenditures were fairly presented. It should be noted that these claims could be valid or erroneous (including fraudulent).

Some examples of documentation problems follow:

- ❑ **Physician.** Medicare paid a physician \$42 for an office visit made by a beneficiary with back problems. The physician's office submitted a copy of the claim and a copy of the financial ledger but, even after numerous written and telephone requests, did not submit any medical records.
- ❑ **Outpatient.** A hospital outpatient department was paid \$785 for eight outpatient physical therapy services provided during a 24-day period. The medical records supplied by the hospital contained support for three of the eight visits. The medical reviewers concluded that the payments for the other five physical therapy services were not supported, resulting in a \$491 overpayment.
- ❑ **DME.** A Medicare contractor paid almost \$3,000 to a DME supplier for 4 months' rental of an electric hospital bed with pressure pad, as well as wound care supplies. The DME supplier did not respond to our requests for medical records. We subsequently went to the supplier's address and found that the office had been vacated. Although the building owner stated that the DME supplier had a 3-month lease which was still current, we were not able to contact the lessors. As a result, we referred the supplier to our Office of Investigations and notified the contractor of our actions.
- ❑ **SNF.** A SNF received \$1,967 for a beneficiary's 19-day stay for skilled nursing care. However, there was no indication in the nurse's notes or elsewhere in the records that skilled nursing care was provided during the period. Because providers may receive reimbursement for SNF services only if skilled care is provided on a daily basis, the \$1,967 payment was denied.

☛ **Lack of Medical Necessity**

A lack of medical necessity was the second highest error category for both FYs 1996 and 1997. In both years, such errors in inpatient hospital and HHA claims accounted for over 60 percent of this error category (FY 1996 - \$5.236 billion of the total \$8.529 billion; FY 1997 - \$4.803 billion of the total \$7.480 billion).

Decisions on medical necessity were made by the contractor or PRO medical staff using Medicare reimbursement rules and regulations. They followed their normal claims review procedures to determine whether the medical records supported the Medicare claims. As illustrated below, the services as billed were often found not medically necessary.

- ❑ **Hospital inpatient.** A beneficiary who had suffered a stroke 5 years earlier was admitted to a hospital to increase her strength. Rehabilitation therapies included occupational, physical, and speech therapies, as well as continuation of routine medications. Based on a review of the medical records, the PRO concluded that the documentation did not support the medical necessity for 37 days (\$38,672) of inpatient hospital care.
- ❑ **HHA.** A \$2,915 HHA claim for home care visits, including skilled nursing services, was denied because the skilled services were medically unnecessary. Our interview with the beneficiary determined that he left home daily and therefore did not meet the definition of "homebound" and was not entitled to Medicare coverage of home health services. Also, we did not find a plan of care signed by the physician in the medical documentation for this care.
- ❑ Another HHA received payment of \$1,484 for home health and skilled services. The medical files did not contain any information supporting that the beneficiary was unable to leave the home without assistance. After reviewing the Medicare homebound criteria, the prescribing physician stated that the beneficiary was not homebound. Therefore, the medical reviewer denied the entire claim.
- ❑ **Transportation.** An ambulance service billed \$7,844 for transporting a beneficiary from a nursing home to a dialysis center. The medical reviewer determined that the medical diagnosis included in the ambulance claim was not supported by medical records and that the beneficiary could have traveled safely by other means.
- ❑ Another ambulance company was paid \$190 for transporting a beneficiary for services that were not medically necessary. In this case, the beneficiary was diagnosed with alcohol dependency. Accordingly, the medical reviewer disallowed the entire payment.
- ❑ **SNF.** A SNF was paid \$4,742 for 17 days of care that were not medically necessary. According to the medical records provided by the SNF, the patient received only nominal assistance with daily living. Therefore, the medical reviewer determined that the beneficiary's daily therapy in a SNF was not medically justified.

❖ **Incorrect Coding**

Incorrect coding is the third highest error category this year, representing 14.67 percent of the total improper payments. Inpatient PPS and physician provider types accounted for over 90 percent of the coding errors for both FYs 1996 and 1997.

The medical industry uses a standard coding system to bill Medicare for services provided. For most of the coding errors, the contractor medical review staff determined that the documentation

submitted by the providers supported a lower reimbursement code. However, we did find a few instances of downcoding which were offset against identified upcoding situations.

Some examples of incorrect coding follow:

- ❑ **Physician.** A physician was paid \$162 for providing critical care, evaluation, and management of an unstable, critically ill patient requiring the constant attendance of the physician in a hospital inpatient setting. According to the medical reviewer, the records submitted by the provider did not support this level of care but rather a noncritical, high-complexity hospital visit valued at \$60. This resulted in a \$102 overpayment.
- ❑ A physician was paid \$96 for an initial patient consultation which required a comprehensive history, a comprehensive examination, and medical decisionmaking of moderate complexity. However, the carrier's medical review staff determined that the physical examination was not comprehensive, as documented by the provider, and that the provider should have billed a lower level of care. An overpayment of \$43 resulted.
- ❑ A physician was paid \$73 for an initial patient consultation which required a comprehensive history, a comprehensive examination, and medical decisionmaking of moderate complexity. However, the carrier's medical review staff determined that the provider's documentation supported a detailed history, detailed exam, and moderate complexity decisionmaking. Because the provider should have billed a lower level of care, a \$24 overpayment occurred.
- ❑ **Hospital inpatient.** A hospital was paid \$22,229 for a surgical procedure based on the principal and secondary diagnosis codes on the claim. In reviewing the medical documentation, the PRO found that the secondary diagnosis code, which indicated complications, was not supported. The PRO's deletion of this code produced a lesser valued diagnosis related group of \$10,151, resulting in a \$12,078 overpayment.
- ❑ **DME.** A Medicare DME supplier was paid \$535 for a gel pressure pad for a beneficiary's mattress. Based on the medical records, the medical reviewer concluded that the supplier had actually provided a pressure pad for a wheelchair, which is reimbursed at \$123. This error resulted in an overpayment of \$412.

☛ **Noncovered or Unallowable Services**

Medicare unallowable services are defined as those that Medicare will not reimburse because the services do not meet Medicare reimbursement rules and regulations. About 73 percent of the errors in this category are attributable to physician claims.

According to the 1996 *Medicare Handbook*, the following services are not covered by Medicare Part B:

- most routine physical examinations and tests directly related to such examinations;
- eye and ear examinations to prescribe or to fit glasses or hearing aids;
- most prescription drugs;
- most routine foot care; and
- chiropractic services, unless the services are for the manipulation of the spine to correct a subluxation demonstrated by x-ray.

Following are some examples of noncovered or unallowable services identified during our review:

- ☐ **Physician.** A physician was paid \$114 for a beneficiary's office visit, electrocardiogram, and various other laboratory tests. After reviewing the medical records submitted by the provider, the medical reviewer determined that payment should be denied because the services were performed as part of a routine physical examination, which is not covered by Medicare.
- ☐ Another physician was paid \$70 for an office visit with complex decisionmaking, as well as three laboratory tests. The medical reviewer concluded that the billed services should be denied because they were actually part of the beneficiary's routine physical examination.
- ☐ A podiatrist was paid a total of \$57 for two claims for providing routine foot care (clipping of toenails). Medicare pays for routine foot care only under limited circumstances, such as for the treatment of infected nails. The medical reviewer concluded that the care provided was routine preventive care, which is not covered, and the claim was denied.
- ☐ **Hospital outpatient.** A physician was paid \$58 for services which, according to the medical records, were part of a routine physical examination. As stated above, Medicare does not cover such examinations.

Conclusions and Recommendations

Medicare, like other insurers, makes payments based on a standard claim form. Providers are required to retain supporting documentation and make it available upon request. As with last year's results, the majority of the improper claims in our sample did not contain any visible errors. However, a significant portion of the errors we found were attributable to a lack of or insufficient documentation on the part of providers that claimed payments. We also identified

numerous errors for services that were not medically necessary, upcoded to obtain higher Medicare payment than the appropriate code would permit, or noncovered or unallowable.

We believe that the FY 1997 audit results confirm that unnecessary or improper payments continue to plague the Medicare program. Without prompt and continued effort in monitoring improper payments, these conditions will continue. However, we acknowledge that too little time has elapsed for HCFA to fully implement our prior year's recommendations and to significantly reduce the error rate.

Specifically, we recommended last year that HCFA:

- Develop a system that estimates improper payments objectively and periodically and disclose the range of such payments in its financial statements.
- Develop a national error rate to focus corrective actions and measure performance in reducing improper payments.
- Report the lack of a national error rate process as a material internal control weakness in the HHS FY 1997 FMFIA report.
- Continue to update its systems' capabilities to keep pace with questionable billing practices.
- Develop and implement stronger deterrents to reduce improper Medicare benefit payments.
- Enhance prepayment and postpayment controls by updating computer systems and related software technology to better detect improper Medicare claims.
- Expand payment safeguard activities and, if necessary, seek additional funding.
- Direct contractors to expand provider training to further emphasize the need to maintain medical records that contain sufficient documentation and the penalties for not doing so.
- Ensure that contractors recover improper payments identified in our review.
- Direct that contractors follow up with specific providers identified in our sample to address documentation and medical necessity concerns and to determine whether other systemic problems need to be corrected.
- Direct contractors to make follow-up evaluations of specific procedure codes with high error rates.

The HCFA generally concurred with our past recommendations and has developed a corrective action plan to reduce the Medicare payment error rate to 10 percent by the year 2002.

Accordingly, we offer no additional recommendations. Specific corrective actions follow:

- **Increasing the level of claims review.** At the beginning of FY 1998, HCFA required its contractors to make a prepayment review of the documentation supporting physician claims for evaluation and management codes. The contractors were also asked to increase their overall level of claims review (prepay and postpay), including review of supporting documentation. In addition, pilot projects with the PROs are planned to review 1-day hospital stays, short-term hospital readmissions, and other selected provider procedures.
- **Increasing the number of contractor medical directors.** Contractor medical directors play an important role in medical review activities and provider education. To increase medical director full-time equivalents by 15 percent, HCFA provided the FIs \$1 million in FY 1998 funding.
- **Improving the use of technology and data.** The HCFA is developing a system architecture that will incorporate technological advances for detecting fraud, waste, and abuse. Currently, all Medicare contractors use software to evaluate provider billing patterns. The HCFA is evaluating the capabilities, strengths, and weaknesses of analytical, off-the-shelf systems currently supporting the contractors' medical review and fraud and abuse activities. The information gathered will be used to assess the adequacy of system capabilities and to fund improvements as necessary.

In FY 1998, HCFA will continue developing and refining the HCFA Customer Information System (HCIS) which provides rapid access to national provider and beneficiary utilization data. The HCIS, in combination with various other software tools, allows contractors to better focus review activities. Additionally, HCFA continues to contract with Los Alamos National Laboratories for development of sophisticated statistical methods that use the information known about providers and beneficiaries to score associated claims for fraudulent and abusive activities. The ultimate goal is to improve prepayment reviews of claims.

- **Developing and implementing a substantive testing program.** Pursuant to an agreement with the OIG, HCFA will have a program fully operational by October 1, 1998, to conduct the substantive testing portion of the FY 1999 financial statement audit and to produce a Medicare payment error rate. To date, HCFA has been working very closely with the OIG to fully understand the audit protocol and methodology applied during the FY 1997 audit. The HCFA has also contracted with a statistician to document the sampling and other methodologies used by the OIG so that HCFA can replicate OIG's methodology in FY 1999.

2. Medicare Other Governmental Liabilities (i.e., Accounts Payable)

Reported Medicare other governmental liabilities totaled \$27.4 billion at September 30, 1997. These liabilities represent the cost of services provided to Medicare beneficiaries but not paid at the end of the fiscal year. The HCFA has made significant improvements in estimating this liability, including the implementation of a revised estimation methodology.

The revised methodology identified the following five major components comprising other governmental liabilities:

- incurred to approved claims,
- approved to paid claims,
- paid to cleared claims,
- cost settlements, and
- periodic interim payments (PIP).

Data reliability concerns were identified in the incurred to approved claims, approved to paid claims, and cost settlement components of the liability estimation process. The extract program for retrieving applicable data used in calculating incurred to approved claims incorrectly summed payments for certain provider types. In addition, some contractors were not able to provide detailed supporting documentation for the approved to paid claims component. Finally, the revised methodology had to be modified to adjust for deficiencies in the data source used to calculate the estimated liability related to the cost settlement component.

The HCFA's review and approval process initially failed to detect the data reliability concerns noted above. It did not ensure that there was adequate supporting documentation for each component, and review and approval of the components were not clearly documented. This process is still evolving.

Recommendations

Management should periodically analyze and review data to assess the reasonableness of their estimate of other governmental liabilities. Specifically, we recommend that HCFA:

- ▶ Periodically validate the data base to ensure the existence and completeness of test data.
- ▶ Use the results of the detailed claims testing to assess the reasonableness of the estimate for other governmental liabilities.
- ▶ Reconcile data obtained from Medicare contractors as part of the quarterly HCFA 1522 reporting process to other HCFA cost settlement data reports.

- ▶ Assess the availability of insurance industry and provider data to establish benchmarks and use this information to assess the reasonableness of the estimate for other governmental liabilities.
- ▶ Reconcile its estimate to the National Claims History File monthly processing reports.
- ▶ Perform a trend analysis of the accounts payable estimate to expenditure history.
- ▶ Periodically validate key information, such as data from contractor 750 reports.

3. Financial Management Controls for Contractors and Preparation of HCFA Financial Reports

The OMB Bulletin 94-01 requires that financial statements be the culmination of a systematic accounting process. The statements are to result from an accounting system that is an integral part of a total financial management system containing sufficient structure, effective internal controls, and reliable data. However, HCFA does not have an integrated accounting system to capture expenditures at the Medicare contractor level. Instead, it relies on a complex system of reporting and ad hoc reports to accumulate data for financial reporting. Our review of the internal control structure at selected Medicare contractors disclosed numerous weaknesses in their ability to report accurate financial information. These weaknesses may be partly due to the absence of certain components of a fully-integrated financial management system, including full accrual accounting, a double-entry general ledger system, proper cut-off procedures, and adequate source documentation. These weaknesses increase the risk of material misstatement in the financial statements. In addition, contractors do not have uniform accounting systems that record, classify, and summarize information for the preparation of financial statements. Moreover, HCFA's central and regional office oversight of contractor operations and financial management controls has not provided reasonable assurance that material errors would be detected in a timely manner.

3(a) Medicare Accounts Receivable

Medicare accounts receivable represent funds owed by providers to HCFA due to overpayments reported by Medicare contractors. These accounts receivable are stated as \$2.5 billion at September 30, 1997, net of the allowance for uncollectible accounts. Medicare contractors were not able to provide sufficient detailed records to support accounts receivable balances reported to HCFA to prepare the yearend financial statements. Many of the deficiencies reported in previous years continued to exist throughout FY 1997, as noted below:

- We could not obtain reasonable assurance of the completeness and support for \$266 million in accounts receivable that a contractor reported as transferred to other Medicare FIs during its transition from the Medicare program. In addition, HCFA has been unable to reconcile, through its 750/751 quarterly contractor financial reports, the

\$266 million to the acquiring Medicare contractors. Based on our review, procedures were either not established or not followed among HCFA and the Medicare contractors to confirm and reconcile the transferred accounts receivable.

- At 9 of the 11 contractors selected for testing, we were unable to obtain assurance of the completeness of accounts receivable. Specifically, detailed subsidiary ledgers could not support accounts receivable balances and/or adjustments reported to HCFA on the 750/751 reports. For example, one contractor could not provide subsidiary ledgers for \$21 million of the \$86 million balance reported to HCFA. Another contractor adjusted (plugged) the "reclassified/adjusted" amount by \$757,821 to reconcile the ending subsidiary balance to the balances reported on the HCFA 750/751. The contractor was unable to explain the variance.
- One contractor reported a \$3 million accounts receivable balance on its MSP tracking report and \$5.5 million on its HCFA 750/751 report as of September 30, 1997. Without extensive audit work, we could not determine which amount was correct.
- Three contractors did not record accounts receivable overpayments in a timely manner. One contractor did not record receivables for final settlement until the payment was received, instead of when it was identified. Contractors took over 50 days to record these overpayments as actual receivables.

As a result of these accounts receivable control weaknesses, HCFA may not be collecting millions of dollars in overpayments from providers. These problems have been addressed in HCFA's current corrective action plan.

3(b) Controls Over Cash

We reviewed the contractors' cash procedures to determine whether adequate safeguards and records were in place and whether duties were properly segregated. These controls typically are designed to protect assets against theft, loss, misuse, or unauthorized alteration and to reduce the opportunities for the occurrence and concealment of errors or irregularities. We identified the following weaknesses:

- Seven of 11 contractors reviewed did not maintain general ledgers or subsidiary ledgers supporting cash balances.
- Four contractors did not properly segregate duties in that the same individuals were responsible for receiving and endorsing checks, preparing and recording deposits, and performing bank reconciliations.
- Five contractors did not apply accounts receivable collections in a timely manner.

- Three contractors did not prepare bank reconciliations in a timely manner and, when prepared, the reconciliations were not adequately documented.
- Two contractors left Medicare checks unsecured.

3(c) Financial Reporting and Reconciliations - Medicare Contractors

The reconciliation of "total funds expended" on the HCFA 1522, Monthly Contractor Financial Report, is an important control which ensures that all amounts reported to HCFA by Medicare contractors are accurate, supported, complete, and properly classified. At the Medicare contractor level, "total funds expended" is the sum of all checks drawn and electronic fund transfer payments issued during the calendar month less voided checks and overpayment recoveries. This amount is then further classified by component into the following categories: benefit payments, PIP, accelerated payments, net suspense payments, audit reimbursement adjustments, and interest income and expenses. The HCFA uses the information from this report in preparing its financial statements.

Our analysis of the HCFA 1522 report at the 11 selected Medicare contractors identified the following internal control weaknesses:

- Paid claim activity and "total funds expended" were not formally reconciled at 7 of the 11 contractors. For example, it took several months for these contractors to produce payment tapes that reconciled with the monthly 1522 reports because adjusting entries were not identified and proper cutoff periods were not used. Improvements were noted at the remaining four contractors due to HCFA/OIG training or prior participation in the FY 1996 CFO audit.
- Several contractors had no internal written policies or procedures for preparing the HCFA 1522.
- In many cases, readily available general ledgers and appropriate subsidiary records were not maintained to support all components of "total funds expended" on the HCFA 1522. For example, to prepare the monthly HCFA 1522 reports, contractors had to obtain data from various sources, such as the computerized claims processing system, bank statements, manually prepared documents and ledgers, and estimates. This data was then manually combined by contractors' accountants into the HCFA reporting formats. However, the source documents were not always maintained or accurate. For example, based on our audit work, three contractors submitted revisions to properly reflect the amounts reported to HCFA on their 1522s.
- Some contractors did not subject the HCFA 1522 to independent verification. For example, one contractor double-counted \$55 million of electronic fund transfers for several months. This had a cumulative effect on subsequent monthly 1522s of

overstating the cash on hand and letter of credit draws. This matter was not detected until we brought it to the contractor's attention.

Although we noted similar weaknesses in our prior internal control reports issued to HCFA, contractors have not effectively implemented the controls necessary to ensure adequate financial reporting.

3(d) Financial Reporting - HCFA Central Office

The CFO Act imposes important requirements on all Federal agencies, including HCFA. Many of these requirements center around the development of annual financial statements in accordance with generally accepted accounting principles. Since Federal agency financial statements are prepared only annually, significant accounting issues are not addressed throughout the year. While HCFA, especially the Division of Accounting, is faced with significant staffing constraints, preparing the financial statements once a year taxes the accounting function beyond its capabilities and is at least partially responsible for certain conditions that were noted this year.

The HCFA's process for preparing annual financial statements is manually intensive, involving a series of spreadsheets which start with general ledger data and adjustments to incorporate Treasury information and contractor information which HCFA has determined is needed as the financial reporting process has evolved. While HCFA's FACS is a dual-entry system, extensive adjustments are made outside this internal control system to prepare the annual financial statements. This increases the risk that material errors may not be detected in a timely manner.

Specifically, we found that:

- The HCFA's primary accounting system, FACS, does not capture all financial data reported by HCFA. For example, Treasury data is reported to HCFA outside of FACS and has a significant impact on the financial statements.
- The HCFA does not have formal written policies and procedures for preparing, approving, or retaining journal entries.
- Controls over the safeguarding of financial reporting spreadsheets, including verification of calculations and password protection, were not adequate. In addition, these spreadsheets, which include prior and current period entries, are not posted to the general ledger. For example, the ending balance in net position at September 30, 1996, did not initially roll forward to the beginning balance for the following year.

Recommendations

To improve financial management controls and financial reporting, we recommend that HCFA:

- ▶ Review and monitor the accounts receivable internal control structure to provide reasonable assurance that reported amounts are valid and documented.
- ▶ Establish an integrated financial management system to promote consistency and reliability in recording and reporting accounts receivable information.
- ▶ Ensure that all contractors establish a general ledger system that incorporates double-entry bookkeeping.
- ▶ Enhance contractor cash controls by emphasizing the importance of segregation of duties, reconciliation processes, and other cash control techniques.
- ▶ Ensure that all contractors develop control procedures to provide independent checks of the validity, accuracy, and completeness of the amounts reported to HCFA, including a reconciliation with the contractors' supporting documentation, and periodically review contractors' control procedures over the reconciliation.
- ▶ Ensure that contractors receive ongoing training on HCFA 750/751 reports.
- ▶ Develop appropriate input/output controls for routinely reviewing the HCFA 750/751 and other reports received from contractors to identify unusual items and inconsistencies and emphasize HCFA's reliance on these reports.
- ▶ Revise reporting requirements to reflect HCFA's expectation and need to retain support, in an auditable format, for significant accounts at each contractor.
- ▶ Explore obtaining software to reduce the manual manipulation of data necessary to develop financial statements, and develop procedures to provide an audit trail and approval of entries and assumptions made.
- ▶ Include the issues relating to financial management discussed in this report in the HHS FY 1998 FMFIA report.

4. Medicare Electronic Data Processing (EDP) Controls

Numerous EDP control weaknesses, as noted on the following page, were found at the HCFA central office and selected Medicare contractors. Specifically, we found deficiencies in entity-wide security programs, access controls, application development and change controls, segregation of duties, systems software, and service continuity planning at the HCFA central

office and/or multiple contractor sites. Access controls, as well as application controls, are being reported as material weaknesses.

Assessment of HCFA Central Office and Medicare Contractors

General Controls and Application Controls

Audit Areas	HCFA Central Office		Medicare Contractors		
	Reportable Conditions	Material Weakness	Reportable Conditions	Material Weaknesses	
General Controls			OIG	SAS 70 ¹	
Entity-wide security	5		15		
Access controls	5	1	31	4	1
Application development and program change controls	3		7	3	
Segregation of duties	1		3		
System software	2		14	1	
Service continuity	1		9	4	
GHP, FACS, EDB, and APPS applications ²	14				
Application controls					
Specific to Florida shared system(FSS)			2	N/A	2
Specific to MCS			2	N/A	1
Specific to CWF			2	N/A	
Input, processing, and output controls			5	N/A	

¹ Statements on Auditing Standards (SAS) 70 reviews are made by independent public accountants under contract to HCFA.

² GHPS is Group Health Plan System, FACS is Financial Accounting Control System, EDB is Enrollment Data Base, and APPS is Automated Payment Plan System.

Background

For FY 1997, HCFA relied on extensive data processing operations at its own offices and at contractors that process and account for \$212 billion in Medicare expenditures. The HCFA central office computer center primarily maintains administrative data, such as Medicare enrollment, eligibility, and paid claims data, but it also processes all payments for managed care.

Medicare contractors use one of several "shared" systems to process and pay Medicare fee-for-service claims. The shared systems interface with the Common Working File (CWF) to obtain authorization to pay claims. The CWF uses nine distributed databases to coordinate Medicare Part A and Part B benefits and to approve claims for payment. These databases are maintained by contractors referred to as CWF hosts, while the shared systems and CWF are designed and maintained by separate contractors referred to as systems maintainers.

Our review of EDP internal controls was limited to general and application controls and did not include management or operations controls. Controls associated with the general data processing environment (general controls) are critical to ensuring the reliability, confidentiality, and availability of HCFA data. These EDP general controls involve the entity-wide security program, access controls, application development and change controls, segregation of duties, operating system software, and service continuity. They affect the integrity of all applications operating within a single data processing facility.

HCFA Central Office

The EDP general controls at the HCFA central office continue to be ineffective. Our assessment disclosed a material internal control weakness over access as well as other weaknesses in the five EDP general control areas.

Specifically, we found deficiencies in entity-wide security programs, access controls, application development and change controls, segregation of duties, systems software, and service continuity planning at the HCFA central office and/or multiple contractor sites. Each of these areas merits additional attention. For example, data security remains a major concern at the HCFA central office. Our prior-year review demonstrated weaknesses in EDP general controls through a system penetration test in which we obtained access privileges to read or modify sensitive Medicare enrollment, beneficiary, provider, and payment information. Although HCFA immediately corrected the prior-year vulnerabilities, our current-year tests resulted in penetrating the mainframe data base. We obtained the capability to modify managed care production files.

Furthermore, we found that data center users without specific authorization to the managed care system have the potential to gain update access to those same files. Although HCFA had already made enhancements in this area during FY 1996, additional effort is necessary to fully secure the mainframe data base. Moreover, our system penetration test revealed additional control problems, including the existence of an unknown bulletin board, the presence of various network

vulnerabilities such as open host sites and available services, and the availability of HCFA's network information unblocked and obtainable from HCFA's Internet service provider. These network-related vulnerabilities could be exploited by unauthorized individuals to compromise one or more of HCFA's computer systems. In addition, subsequent to our field work, HCFA initiated an in-depth security self-assessment, including a sophisticated network penetration test disclosing several weaknesses. The HCFA is actively developing an appropriate corrective action plan.

The entity-wide security program should provide a framework for managing risk, developing security policies, assigning responsibility, and monitoring the adequacy of computer-related controls. However, our 1997 work disclosed that HCFA had not performed risk analyses, developed security plans, or ensured that proper corrective action was taken for its general support systems, including the computer center, telecommunications, and networks, and significant applications. As a result, HCFA management has no assurance that cost-effective controls are implemented to manage risks associated with the systems. In addition, the security structure was not adequate to ensure that security program objectives are achieved.

Serious weaknesses in application development and change controls are still outstanding from the FY 1996 audit. The centralized production control group controlled only about 15 percent of the production batch programs. In addition, HCFA did not use its library management software to provide version control over the application source code or ensure that the executable program code was created from the appropriate source code. Because of these weaknesses, HCFA risks implementing unauthorized programs, which could result in improper processing of Medicare claims or eligibility information or allow malicious programming changes that could interrupt data processing or destroy data files and programs.

The HCFA also has not addressed the prior segregation of duties issue. We noted that electronic data processing functions were not adequately separated to prevent one individual from controlling key aspects of computer-related operations.

Controls over operating system software integrity remain ineffective. As noted in our FY 1996 audit, this software was not adequately restricted, and HCFA still allows an excessive number of contractors and systems personnel to have update access to the software. This excessive access increases the risk of accidental corruption of the operating system. In addition, the operating system software parameters could be overridden during system generation or "reboots," which could result in a different mainframe configuration.

Finally, serious weaknesses in service continuity controls have not been resolved. Continuity controls should ensure that critical operations continue without interruption or are promptly resumed and that critical and sensitive data are protected when unexpected events occur. The HCFA has not updated its critical application list in the contingency planning document since 1992. Because several applications have been developed, modified, or combined since then,

HCFA's contingency plan cannot ensure that its critical applications would be promptly restored in the event of a disaster.

Medicare Contractors

The EDP general controls were assessed at 14 Medicare contractors, including 3 systems maintainers and the 6 SAS 70 locations. We concluded that four Medicare contractors and four of the five CWF host sites had effective general controls. However, these locations had significant weaknesses in many of the six areas of general controls. Specifically, we are reporting application change controls to be a material internal control weakness, as discussed below. In addition, although SAS 70 reports do not contain a separate conclusion on EDP controls, five of the six SAS 70 locations had exceptions noted on EDP controls. Further, one Medicare contractor and one CWF host site had ineffective general controls, and two of the three shared systems had ineffective controls.

We noted material control weaknesses related to the FSS (Part A) and MCS (Part B) shared systems. For the FSS, data centers had full access to the source code and could perform local changes to FSS programs. These changes were not subjected to the same controls that exist in the standard FSS change process. Additionally, one data center developed an override library to give priority to locally modified FSS programs. Consequently, the local programs always override the standard FSS programs provided by the maintainer. For the MCS, each individual carrier could deactivate HCFA-mandated edits. The lack of a controlled modification process over the shared systems does not ensure that only authorized programs are implemented and executed by FIs and carriers.

For the entity-wide security program, two reportable conditions were common to most contractors: entity-wide risk assessments were not performed, and organization-wide security plans were not documented. Regarding access controls, we noted one material control weakness related to inadequate physical security at a contractor facility. We were able to enter and exit that facility without proper identification and verification. Also for the access control area, most contractors visited had three reportable conditions: individuals were granted inappropriate access to the data center, dial-up telephone numbers were not periodically changed, and data and resource classifications were not available. Regarding application software development and program change controls, most of the weaknesses related to library management.

For segregation of duties, the common reportable condition was the lack of documented policies and procedures on separation of incompatible duties. For system software, four reportable conditions were common: personnel had inappropriate access to and reporting of sensitive utilities, inappropriate libraries were resident in the authorized program facility, logs or system management facility data sets could be altered by systems personnel, and the systems environment could be reconfigured by computer operators during initial program loads or by "rebooting" the system. Pertaining to service continuity, two contractors did not have a current disaster recovery plan. This issue is critical to the recoverability of Medicare systems.

Further, as evidenced by the varied findings among the Medicare contractors, HCFA does not have a consistent set of policies to oversee and review the effectiveness of general controls at its contractors. As such, HCFA has not adequately monitored these contractors in prior years. However, in response to prior recommendations, in FY 1996 HCFA began a program to contract EDP control assessments at selected contractors.

Conclusion and Recommendations

Medicare relies on automated systems to administer virtually all aspects of the program. However, material weaknesses exist at the HCFA central office system, two of the Medicare contractors, and two of three shared processing systems.

For the central office EDP controls, we recommend that HCFA implement cost-effective improvements to ensure that:

- ▶ An entity-wide security structure is developed to achieve security program objectives. Specifically, HCFA should ensure that easily guessed passwords (e.g., system passwords used by installers and passwords related to functions being performed) are not used, enforce periodic password changes, and record and track access to sensitive data with a hard copy report sent to the responsible system manager.
- ▶ Access controls are adequate to protect data and other resources from unauthorized modification or destruction.
- ▶ Application development and program change control procedures protect against unauthorized changes.
- ▶ Assigned responsibilities adequately segregate computer-related duties.
- ▶ Controls over system software integrity and changes properly restrict access to authorized personnel and protect against unauthorized changes.
- ▶ Service continuity plans are current and periodically tested.
- ▶ The material weaknesses associated with the HCFA central office and Medicare contractors are reported in the HHS FY 1998 FMFIA report.
- ▶ The periodic evaluation of contractor EDP controls continues, and all findings and recommendations are tracked through final implementation.

For the Medicare contractor EDP controls, we recommend that HCFA coordinate with contractors to ensure that:

- ▶ The FSS changes are authorized, documented, and tested to maintain the integrity of the application. Additionally, override libraries should be further examined to determine the necessity of their use.
- ▶ Carriers do not modify mandated edits and essential audits in the MCS application, and claims are processed in accordance with existing Medicare regulations.
- ▶ An entity-wide security structure is implemented to achieve security program objectives, access controls are adequate to protect data and other resources from unauthorized modification or destruction, application development and program change control procedures protect against unauthorized changes, assigned responsibilities adequately segregate computer-related duties, controls over system software integrity and changes properly restrict access to authorized personnel and protect against unauthorized changes, and service continuity plans are current and periodically tested.

REPORTABLE CONDITIONS

1. HCFA Regional Office Oversight of Medicare

The HCFA regional offices have oversight responsibility for Medicare contractors. A majority of the oversight efforts are conducted under the Contractor Performance Evaluation (CPE) review process. The purpose of CPE is to evaluate Medicare contractors' compliance with contracts, laws, and regulations.

Contractors prepare and submit periodic financial reports to HCFA for use in preparing HCFA's financial statements. However, at the three regional offices we visited, oversight activities were not adequate to ensure that financial data provided by contractors is reliable, accurate, and complete. Specifically, our review identified the following problems:

- Contractors report benefit payments on the HCFA 1521/1522 forms and are responsible for reconciling these amounts to their accounting records. The regional offices do not ensure that the contractors perform this reconciliation and do not verify the validity of the benefit payment data.
- The Audit Quality Review Program, designed to evaluate contractors' performance in the auditing and settlement of Medicare cost reports, is not being applied to enough cost reports to provide adequate assurance of the validity of the total cost settlements.
- On a quarterly basis, contractors are required to submit HCFA 750A/B (Statement of Financial Position) and HCFA 751A/B (Status of Accounts Receivable) to the regional

offices. The regional offices, however, perform either no onsite reviews or very limited reviews of these reports, and the reviews that are conducted do not include testing the validity, accuracy, or completeness of the reported data.

- New regulations effective January 2, 1997, require regional office concurrence before suspending payments to a provider on the basis of fraud or abuse. To properly oversee and ensure that proper sanctions are imposed, the regional offices need accurate data on all contractor referrals of fraud and abuse cases. But the regional offices are not tracking new and pending fraud and abuse cases filed by contractors directly with the OIG.
- The regional offices review the contractor MSP program in accordance with a protocol that meets requirements specified in the regional office manual. However, not all procedures in the protocol are applied to each contractor each year, nor is there a documented risk assessment of contractor MSP operations for deciding which contractors and contractor functions to review.
- Two major on-line reporting systems are used to track the status of Medicare overpayments identified by the contractors. The Provider Overpayment Report (POR) is used by FIs (Part A), and the Physician/Supplier Overpayment Report (PSOR) is used by carriers (Part B). The regional office oversight responsibility includes monitoring and evaluating contractor overpayment identification and collection activities. The regional offices we reviewed did not make any Part A onsite reviews of the accuracy of the contractors' input into the POR system, and the Part B reviews were not adequately documented to support the procedures performed and the findings.
- Contractors are required to submit annual certifications of their internal controls for compliance with certain laws and regulations. However, the regional offices do not evaluate the accuracy and reliability of the documentation supporting the certifications.
- Change management plans (formerly task management plans) are prioritized changes mandated by the HCFA central office to be completed by contractors on a quarterly basis. The majority of these changes involve edit changes to the claims processing systems. A shared system maintainer is responsible for implementing the changes and disseminating information to system users. The regional offices do not make systems tests to ensure that the change management plans are properly and timely implemented.
- Contractors enter cost report settlement data into the System Tracking of Audit and Reimbursement (STAR) report. The regional offices are responsible for monitoring the contractors' timely settlement of cost reports by reviewing the STAR reports. However, the regional offices have not made any recent onsite reviews of the contractors' supporting documentation to verify the accuracy of the data entered into the STAR system.

Recommendations

We recommend that HCFA:

- ▶ Increase their oversight of Medicare contractors' financial reporting data.
- ▶ Periodically test the validity of submitted financial information and obtain supporting documentation.
- ▶ Ensure that the contractors reconcile various financial reports, such as the 750/751 to POR and PSOR and the 1522 to the paid claims file.
- ▶ Develop corrective action plans for resolving past as well as current OIG financial statement findings and recommendations and follow up to determine effective implementation.

2. Federal Share of Medicaid Accounts Payable and Accounts Receivable

Federal financial accounting standards require that the Federal portion of Medicaid accounts payable and accounts receivable recorded by the States be recorded in the Medicaid program's financial statements. In an attempt to accumulate this information, HCFA distributed a survey form to the States in 1996 and 1997. Based on the survey results, HCFA estimated the net liability as of the end of each fiscal year and recorded these amounts in the financial statements.

The survey information on the Federal share of accounts receivable received by HCFA was very limited. In addition, most of the information received was as of June 30, 1996 and 1997. Our testing showed that the accounts receivable balances can be fairly volatile from State to State and from month to month within a State. Since HCFA received only limited information and did not receive the information as of the fiscal yearend, accurately estimating the total Federal share of accounts receivable is very difficult.

Recommendation

We recommend that HCFA improve its estimate of the Federal share of Medicaid accounts payable and receivable through the following procedures:

- ▶ The HCFA should continue its annual survey but should send the survey well in advance of the due date and include clear, comprehensive instructions.
- ▶ Survey responses should be carefully monitored and procedures implemented for second requests, telephone follow-ups, and guidance to State personnel in completing the survey.

- ▶ Trend data of accounts receivable and accounts payable over time should be developed for each State and used to improve and further refine the estimation model.

3. HCFA Regional Office Oversight of Medicaid

One of the primary responsibilities of the regional offices is to ensure that the States submit timely, accurate financial reports and comply with various laws and regulations. However, as noted below, many oversight procedures previously performed by the regional offices have been severely reduced or eliminated in recent years:

- The regional offices have reduced their emphasis on reviews of the quarterly HCFA 64 packages and have placed increased reliance on systems and controls verified by other agencies or States and less emphasis on detecting errors and irregularities.
- Effective in June 1996, HCFA eliminated all Federal requirements for using the Claims Processing Assessment System for those States operating on the approved Medicaid Management Information System (MMIS). However, the regional offices have not instituted procedures to determine whether programs developed by the States are sufficient to properly examine and evaluate the accuracy of claims processing.
- Pursuant to section 4753 of the Balanced Budget Act of 1997, HCFA no longer has authority to perform system performance reviews of each State's MMIS.
- The regional offices have been unable to devote sufficient resources to reviewing and reporting on the States' procedures for identifying fraud and abuse and collecting recoveries.
- The regional offices have not been able to review all States for compliance with regulations relating to disproportionate share payments.

Recommendation

We recommend that HCFA review the entire regional office oversight process and develop or reenact policies to provide sufficient oversight of the States' Medicaid claims processing and reporting.

In addition to the reportable conditions described above, we noted certain matters involving internal control weaknesses which we reported to HCFA management in a separate letter dated March 4, 1998.

REPORT ON COMPLIANCE WITH LAWS AND REGULATIONS

Except for the matters discussed on pages 1 and 2 of our report on the financial statements, we conducted our audit in accordance with generally accepted auditing standards; *Government Auditing Standards*, issued by the Comptroller General of the United States; and OMB Bulletin 93-06, *Audit Requirements for Federal Financial Statements*. These standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements referred to above are free of material misstatement.

The HCFA management is responsible for complying with applicable laws and regulations. As part of obtaining reasonable assurance about whether HCFA's financial statements are free of material misstatement, we performed tests of its compliance with certain provisions of laws and regulations, noncompliance with which could have a direct and material effect on the determination of financial statement amounts and certain other laws and regulations specified in OMB Bulletin 93-06, including the requirements referred to in the Federal Financial Management Improvement Act (FFMIA) of 1996. We also obtained an understanding of management's process for evaluating and reporting on internal control and accounting systems as required by the FMFIA and compared the material weaknesses reported in HCFA's FMFIA report that relate to the financial statements under audit with the material weaknesses and other reportable conditions found during our evaluation of HCFA's internal controls. In evaluating HCFA's internal controls and conducting substantive audit procedures, we identified certain reportable conditions that were not included in HCFA's FMFIA report.

Material instances of noncompliance are failures to follow applicable laws and regulations to the extent that the effects of such noncompliance, in the aggregate, cause the financial statements to be misstated. The results of our tests of compliance disclosed a material instance of noncompliance. Specifically, as discussed on page 5 of this report, through detailed medical and audit review of a statistical selection of 600 beneficiaries nationwide with 8,048 fee-for-service claims processed for payment during FY 1997, we found that 1,907 claims did not comply with Medicare laws and regulations. By projecting these sample results, we estimated that FY 1997 net overpayments totaled about \$20.3 billion nationwide, or about 11 percent of total Medicare fee-for-service benefit payments. The estimated range of the improper payments at the 95 percent confidence level is \$12.1 billion to \$28.4 billion, or about 7 percent to 16 percent. The estimated effect of the material Medicare fee-for-service noncompliance has been reflected in HCFA's FY 1997 financial statements.

We performed tests of compliance to determine whether HCFA's financial management systems substantially comply with the Federal financial management systems requirements, applicable accounting standards, and the United States Standard General Ledger at the transaction level. To meet this requirement, we performed tests of compliance using the implementation guidance for FFMIA issued by OMB on September 9, 1997. Our tests of HCFA's Year 2000 planning were limited to obtaining and reading the applicable Year 2000 progress reports submitted to HHS.

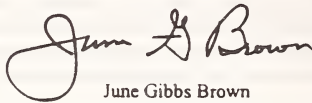
An audit of financial statements conducted in accordance with generally accepted auditing standards, *Government Auditing Standards* issued by the Comptroller General of the United States, and OMB Bulletin 93-06 is not designed to determine HCFA's readiness for Year 2000. Further, we have no responsibility with regard to HCFA's efforts to make its systems, or any other systems, such as those of HCFA's vendors, service providers, or any other third parties, Year 2000 ready or to provide assurance on whether HCFA has addressed or will be able to address all of the affected systems on a timely basis. These are responsibilities of HCFA's management.

The results of our tests disclosed instances in which HCFA's financial management systems did not substantially comply with some of the requirements discussed in the second preceding paragraph. The *Report of Independent Auditors on Internal Control* includes information related to the financial management systems that were found not to comply with the requirements, relevant facts on the noncompliance, our recommendations related to the specific issues presented, and relevant comments from HCFA management responsible for the noncompliance, including management's proposed action plan. These instances of noncompliance relate to accounting and EDP systems at the HCFA central office and at Medicare contractors and are presented below:

- The HCFA does not have an integrated accounting system to capture expenditures at the Medicare contractor level.
- The HCFA's process for preparing annual financial statements is manually intensive, involving a series of spreadsheets that incorporate general ledger data as well as Treasury information, contractor information, and adjustments determined by HCFA.
- The HCFA central office and Medicare contractor access and application control weaknesses are significant departures from requirements in OMB Circulars, A-127, *Financial Management Systems*, and A-130, *Management of Federal Information Resources*.

Providing an opinion on compliance with certain provisions of laws and regulations was not an objective of our audit and, accordingly, we do not express such an opinion.

This report, which incorporates HCFA's informal comments where appropriate, is intended for the information of HCFA, the Secretary, and OMB. However, this report is a matter of public record, and its distribution is not limited.



June Gibbs Brown
Inspector General
Department of Health and Human Services

Independent Auditor's Report Inspector General's Report on the HCFA Financial Statements for FY 1997 Page 36 of 36

Mr. BARTON. Thank you. Your entire written statement will be included in the record.

Ms. DeParle.

STATEMENT OF HON. NANCY-ANN MIN DePARLE

Ms. DEPARLE. Thank you, Mr. Chairman. I am pleased to be here today to discuss the findings of the fiscal year 1997 CFO audit, and I want to thank all of you for staying here and being here for this, because it is one of the most important things that we do at HCFA, together with the Inspector General.

I want to begin by thanking my colleague, June Gibbs Brown and the rest of her team, especially Joe Vengrin, for the cooperative and collegial approach that they took in helping us get through this audit. They did many, many days of hard work. It is a true public service, and I want to thank them for what they have done.

I am pleased to report that this year's audit demonstrates that aggressive corrective actions are beginning to have an impact. I think we are getting our books in order and we are trying to get our house in order. We have cleaned up our accounts payables, we have corrected our accounting problem with the Social Security Administration, and we are making progress on our accounts receivable. This is only the second year, as you know, that this type of comprehensive audit has been done. The results of the fiscal year 1996 audit helped improve our accounting systems and highlighted areas in which our systems and operations could be tightened. The results of the fiscal year 1997 audit will once again sharpen our focus.

Chairman Horn, I would like to thank you in particular for your leadership in making this audit a reality. As you can see, it is beginning to yield some tangible results and it certainly provides a valuable road map in directing us to areas that crucially need attention. It has become one of the most important tools that we have.

We are continuing to step up efforts to stop improper payments. Since the beginning of this administration, we have taken unprecedented steps to fight fraud, waste and abuse. We are achieving record increases in investigations, indictments, convictions, fines, penalties and restitutions. Last year, Medicare saved an estimated

\$7.5 billion, mostly by preventing inappropriate payments, through audits, medical reviews and other integrity efforts. Also, nearly \$1 billion was returned to the Medicare trust fund, thanks to our law enforcement partners and the Inspector General.

Now, the President is proposing several additional tools we need, such as user fees, that will boost efforts to prevent improper payments. These new proposals, plus initiatives that were implemented after the period covered by the audit report, obviously aren't reflected in today's audit findings. As Ms. Brown said, the auditors estimate that improper Medicare payments were 11 percent, or \$20.3 billion. This suggests a \$3 billion step in the right direction from last year's 14 percent error rate and \$23 billion improper payment estimate, and I believe corrective actions that we are taking are beginning to have an effect. But, as Ms. Brown said, we must be careful not to overinterpret these hopeful estimates, and I want to be clear, Mr. Chairman, that an 11 percent error rate still is not acceptable to me or to Secretary Shalala or, I am sure, to you.

We are pleased that the auditors issued a qualified opinion rather than a disclaimer of opinion this year. We have corrected two items disclaimed in last year's audit and I think all of this demonstrates substantial progress on operational and financial reporting issues since last year's audit. But I would just echo what others here have said, which is that much remains to be done.

Last year the Inspector General recommended, and again this year she recommended, that we expand payment safeguard activities and, if necessary, seek additional funding. We did that last year and we are doing it again this year, and we need your help. The President's budget proposes to allow us to collect \$395 million in user fees. We will dedicate these funds to doubling the number of audits, and increasing medical reviews and other efforts to fight waste, fraud and abuse that will improve our claims error rate.

We also need your help in passing contractor reform legislation. We have requested these reforms, I think, for the past 4 years, and they would help increase competition for Medicare contractor business, they would give us much needed leverage to negotiate with contractors, and they would allow us to hold contractors accountable in the way that we are not able to now. Legislation for both of these proposals was sent to Congress in February.

I think it is important for me to stress that we cannot determine what portion of improper payments that you are hearing about today identified in this audit were due to fraud and abuse. Many of them, as Ms. Brown testified, were due to inadequate documentation, which, as you know, is not synonymous with fraud and abuse. It doesn't necessarily mean that the service was not rendered or that it was not appropriate, although there are some cases of that, but what it does mean is that we must continue working aggressively with our providers to improve documentation. Success in improving documentation will help bring the error rate down, and we are committed to doing that.

We have taken a number of corrective actions focused on improper payments. First of all, I think you will be glad to know that we recovered 95 percent of the overpayments that were identified in last year's audit, and we immediately began collecting those

identified this year. We have already given the list out to our contractors.

We have increased medical review funding by \$53 million over the fiscal year 1997 levels. We are conducting thorough prepayment reviews of documentation, which is the biggest area identified in the Inspector General's report, through prepayment reviews of documentation on a random sample of physician office visit claims and working with providers to refine documentation guidelines, and I expect some of you have heard from the physician community and others about these activities.

We are developing a substantive testing process to help determine whether services are actually rendered and medically necessary, and our peer review organizations in the States are developing pilot programs to test ways to ensure the medical necessity of inpatient hospital claims, which is another area that the Inspector General identified.

We have increased by 15 percent the number of physician medical directors at our claims processing contractors, and we are exploring new technologies like our existing correct coding initiative system and some others, Mr. Chairman, that we have talked to you about to use computer edits to help identify improper claims.

We also expect the error rate to decrease because of other steps we are taking. For example, in March of this year we published a regulation allowing us to hire special program safeguard contractors, who will bring a new energy, we hope, to our program integrity efforts, and that was a result of something that Congress did in the Health Insurance Accountability and Portability Act. We have tightened entry standards and required surety bonds for home health agencies and durable medical equipment suppliers, and we have obtained authority to bar felons from participating in Medicare and Medicaid, and I think all of these things will begin to have results.

So while there is still much work to be done for HCFA to improve the results of its CFO audit, I would say that I am pleased with the progress that we have been able to make in 1 year, and I want to say that a lot of that is due to the help and support and commitment that I have received from those of you in the Congress. With your help and support, I think we will continue to make the improvements that we need to make to ensure that the Medicare program is well managed, financially sound and free from waste, fraud and abuse and that is my goal, and I know that it is yours as well. Thank you.

[The prepared statement of Hon. Nancy-Ann Min DeParle follows:]

PREPARED STATEMENT OF HON. NANCY-ANN MIN DEPARLE, ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION

INTRODUCTION

Chairman Barton, Chairman Bilirakis, Chairman Horn, and Members of the distinguished Subcommittees here today, I am pleased to have this opportunity to discuss with you the findings of the Fiscal Year (FY) 1997 Chief Financial Officers (CFO) audit by the Department of Health and Human Services Office of the Inspector General (OIG). As you know, this is the second year that the OIG conducted this comprehensive audit, which looks at our financial statements and whether we pay claims properly.

I am pleased to report that this year's audit demonstrates that corrective actions initiated following the first such audit last year are having an impact. We are getting our books in order. We have cleaned up our accounts payables. We have corrected our accounting problem with the Social Security Administration, and are making progress on our accounts receivables.

Since the beginning of this Administration, we have taken unprecedented steps to fight health care waste, fraud and abuse. We already are achieving record success in increasing fraud and abuse investigations, indictments, convictions, fines, penalties, and restitutions. Last year, Medicare alone saved an estimated \$7.5 billion—mostly by preventing inappropriate payments—through audits, medical reviews, and making sure other insurers who cover our beneficiaries pay claims that are not Medicare's responsibility. And, nearly \$1 billion was returned to the Medicare Trust Fund, thanks to our partnership with the HHS Inspector General, Department of Justice, and state and local authorities. We have continued to step up our crack-down on waste fraud and abuse, and many of these new initiatives are not reflected in this year's OIG audit report.

The OIG estimates that improper Medicare payments in FY 1997 ranged from 7 percent (\$12.1 billion) to 16 percent (\$28.4 billion), with a point estimate of 11 percent (\$20.3 billion). Although the FY 1997 point estimate of the error rate is \$3 billion less than the FY 1996 point estimate, based on the limited sample of Medicare claims reviewed in both FYs 1996 and 1997, the IG is unable to conclude that this year's error rate is statistically different from last year's error rate.

The OIG issued a qualified opinion rather than a disclaimer of opinion. The Health Care Financing Administration has corrected two items which were disclaimed in last year's audit. All of these acts demonstrate that HCFA has made substantial progress in addressing both operational and financial reporting issues in the short time since last year's audit.

We believe that the actions we have taken are having an effect. Still, much remains to be done. Clearly, a 7 to 16 percent for a claims error rate is not acceptable. As you know, combating waste, fraud and abuse in Medicare is one of my top priorities. We will continue to aggressively implement corrective actions to address the error rate.

One area in which we need your help is in enacting the President's budget proposals to allow us to collect user fees. The Administration has put forth a proposal to collect \$395 million in user fees that will be dedicated to doubling the number of audits and increasing medical reviews and other efforts to fight waste, fraud and abuse. An additional \$264.5 million in user fees for provider enrollment, survey and certification, and duplicate, unprocessable or paper claims are also needed to increase scrutiny and promote program integrity.

We also need your help in passing contractor reform legislation that will increase competition for Medicare contractor business, give us much-needed leverage to negotiate with contractors, and allow us to hold contractors accountable. Legislation for both these proposals was sent to Congress in February.

It is important to stress that we cannot determine what portion of the improper payments identified in the audit were due to fraud and abuse. Many of the erroneous payments were due to inadequate documentation, which is not synonymous with fraud and abuse. It does not necessarily mean the service was not rendered or that it was not medically appropriate. It does mean we must continue working diligently with providers to improve documentation. Success in improving documentation will help bring the error rate down.

We also expect the estimate of improper payments to decrease because of other steps to increase the crackdown on fraud, waste and abuse begun by the Clinton Administration in 1993. For example, in March of this year we published a regulation allowing us to hire special program safeguard contractors who will bring a new energy to our program integrity efforts. That is only one of several additional new steps taken since the end of the fiscal year examined in the audit. Other steps taken since the period covered by the audit include tightening entry standards and requiring surety bonds for home health agencies, expanding on-site inspection for durable medical equipment suppliers and community mental health centers, and obtaining authority to bar felons from participating in Medicare and Medicaid.

The audit of HCFA's financial statements was conducted in accordance with the Chief Financial Officers Act. In 1994, President Clinton signed the Government Reform and Management Act, which made changes to the Chief Financial Officers Act by requiring government-wide and department-wide financial statements. This legislation, which originated in Chairman Horn's Subcommittee, was meant to improve systems of accounting, financial management, and internal controls throughout the Federal government to help reduce waste and promote efficiency, and to provide

Congress with complete, reliable, and timely information on the financial status of the federal government.

Chairman Horn, your leadership in this area is yielding tangible results. Such audits were never done before, and they provide a valuable roadmap directing us to areas that need attention. The results of the FY 1996 audit helped improve our accounting systems and highlighted areas in which our operations could be tightened. We have cleaned up our accounts payable problems, our Social Security Administration receivables are no longer disclaimed. And we are doubling the number of audits for home health and increasing medical reviews by more than 10 percent.

The results of the FY 1997 audit will once again sharpen our focus on areas that need prompt attention. Today I will first discuss the audit findings, and then focus on the corrective actions HCFA is taking.

AUDIT FINDINGS

In conducting this audit, the OIG found that, based on the information sent in to us by providers on their claims, our contractors paid the claims correctly 98 percent of the time. The true error rate was found only when the OIG invested a great deal of resources into visiting HCFA contractors, requesting supporting documentation from providers, and actually reviewing the medical records of 8,048 fee-for-service claims paid in FY 1997 for 600 beneficiaries. The error rate identified by the OIG could only be found by requesting supporting documentation and medical records from providers. Human review of medical documentation identified these errors; automated review alone will not solve this problem. This is a very expensive, labor intensive process, and we do not have resources to do this kind of extensive investigation for every claim.

In the case of 1,907 of the claims, the auditors found that the provider's files could not support that the claim was in accordance with Medicare laws and regulations. By projecting these results to the general Medicare population, the OIG arrived at a midpoint estimate of \$20.3 billion in improper payments nationwide or about 11 percent of the total Medicare fee-for-service benefit payments. Due to the limited size and variance of the sample, however, the true level of improper payments could range from 7 to 16 percent. I remain committed to aggressively rooting out claims for services which are medically unnecessary, insufficiently documented, noncovered by Medicare, or incorrectly coded.

Documentation

Documentation problems are the single largest factor in our error rate. Like other insurers, Medicare regulations require providers and suppliers to submit claims for the services they bill and maintain documentation to substantiate the claim. When the OIG requested documentation from the provider to back up a claim, documentation was not complete in 25 percent of cases.

In 4 percent of cases documentation was never furnished. That is down substantially from 14 percent in FY 1996, and we would like to thank the provider groups with whom we have worked since last year to educate their members on the importance of cooperating with this audit.

The OIG also noted that 14.5 percent of the error rate was attributable to documentation which was unavailable because of ongoing criminal or civil investigations. I must caution that these cases are under investigation and we do not know for sure whether they are actual cases of fraud or even improper payments.

I would also like to stress that these documentation problems do not appear to be related to what some providers consider to be the complexity of documentation requirements. If that were the case, more errors would be classified as incorrect coding where the provider billed for a different level of service than was actually provided, instead of as insufficient documentation where we find that the only documentation is a note stating that the patient is "stable."

Lack of Medical Necessity

The second largest factor in improper payments is claims for services that are not medically necessary. Thirty six percent of the improper claims were identified by medical professionals who found that the documentation provided did not show that the service was medically necessary. These cases include obvious abuses:

- A hospital which admitted a patient five years after a stroke to provide medication and physical therapy for 37 days. Our Peer Review Organizations are developing pilot programs for detecting and preventing this kind of inappropriate admission.
- A home health agency which provided \$3,000 in services to a beneficiary who did not qualify for the benefit. We are taking many steps to crack down on home

health waste, fraud, and abuse, including tougher standards for agencies to enter the program, increased scrutiny for those already in, and a new payment system with incentives to provide only medically necessary care.

Incorrect Coding

Incorrect coding is another significant problem that we are addressing. Payment for services is based in part on how complex a service is. A provider receives a larger payment for more intensive services. Providers use the medical industry's standard coding system to indicate the intensity of the medical treatment on a claim. In 14 percent of the improper payments, medical professionals who reviewed the documentation concluded that the service was not as complex as the provider claimed, and that Medicare had therefore paid too much. Submitting claims for a higher level than actually provided is known as "upcoding." It is also important to note that the OIG found a handful of cases in which the provider down-coded and so was underpaid for the services performed. The audit, however, reports the net improper payment.

Noncovered Services

Finally, about 2 percent of the improper payments were for services not covered under Medicare benefits. Such claims were carefully disguised to look like Medicare-covered services, but upon review of the documentation, medical professionals concluded they were for services that fee-for-service Medicare by law does not cover, such as routine physical examinations, routine ear and eye examinations and most routine foot care.

Durable Medical Equipment

Durable Medical Equipment (DME) is one of the most problematic areas in Medicare in terms of program integrity. It was not included in last year's CFO audit, but is included this year. Therefore, caution is in order before any direct comparisons are made between this year's results and last year's. The audit found that nearly 10 percent of the error rate was due to DME claims, suggesting that we are concentrating our efforts through Operation Restore Trust and other initiatives to address DME waste, fraud and abuse in the right places.

CORRECTIVE ACTIONS

More than 80 percent of the incorrect payments found in the 1997 audit occurred in five areas: physician services (29 percent), inpatient hospital services (20 percent), home health agencies (13 percent), outpatient hospital services (10 percent), and durable medical equipment (10 percent). The remaining 28 percent were made in other categories. Two of these categories, home health and skilled nursing facilities are, along with (DME), high-priority areas for investigation as part of our Operation Restore Trust anti-fraud initiative. Several additional initiatives, discussed later in this testimony, are underway to address home health and DME issues.

Even before last year's audit was released, HCFA began a set of aggressive corrective actions that address problems outlined in the CFO audit and help stop improper payments, including: recouping identified overpayments, increasing claims review and audits, stepping up efforts to educate providers, working to revise documentation guidelines so they are more comprehensive and easier to use, and developing and adopting more sophisticated technologies for detecting fraud, waste and abuse.

First and foremost, we are recovering the improper payments identified by the OIG. We have already recovered 95 percent of the overpayments identified in the FY 1996 sample. We have intensified payment recovery efforts overall, and our contractors will immediately begin collecting the improperly paid Medicare monies identified in the FY 1997 audit. And we will instruct our contractors to evaluate providers identified in the OIG audit report for more extensive review.

Second, we are increasing the level of medical review from 80 million in FY 1997 to 89 million in FY 1998. We also are asking for authority to collect user fees that will allow us to do even more. We have increased funding by \$53 million over FY 1997 levels for medical review. We also are conducting thorough prepayment reviews of documentation on a random sample of physician office visit claims throughout this fiscal year. So far about five thousand of these claims have been denied or reduced because physicians failed to adequately document the claim. We are now working to develop a substantive testing process which will help determine whether services are actually rendered and medically necessary, allow for projection of a national claims error rate, and help to spot areas for improvement. HCFA and our Peer Review Organizations are developing pilot programs to test ways to ensure the medical necessity of inpatient hospital claims. The projects will focus on identifying

unnecessary admissions, unnecessary readmissions, and the necessity of billings for specific cardiac procedures.

Third, HCFA is emphasizing the need for clear and complete documentation. HCFA is working to engage the provider community in a campaign to promote correct coding and documentation. We have held meetings with the professional provider organizations to explain the audit findings and to enlist their help in addressing problems identified in the CFO audit, including publication of information on provider documentation guidelines and on the CFO audit in their materials and newsletters.

We are working with the AMA and medical societies throughout the country to refine the documentation guidance so it is easier to use. We will participate in a meeting the AMA is hosting on April 27 with leaders and billing experts from the national medical specialty societies on how to improve these revised guidelines before they are implemented.

We have increased by 15 percent the number of physician medical directors at our claims processing contractors. These physicians help develop medical review policies and educate the providers about coding, billing and payment policies.

Fourth, HCFA will support the use of existing technology and explore new technology to aid our contractors in identifying improper claims. These efforts include our Correct Coding Initiative, our enhanced Customer Information System, and hiring of special statistical analysis contractors.

Correct Coding—Implemented in 1996, the Correct Coding Initiative is a package of more than 93,000 automated edits we require contractors to have in their claims processing systems. This initiative saved almost \$217 million in the first year of implementation alone. HCFA will continue to develop coding and produce additional edits to enhance contractor databases.

Enhanced HCFA Customer Information System (HCIS)—The HCIS, which was first used as a part of Operation Restore Trust, enables HCFA and its contractors to view provider or service utilization data at several levels including the national, the state, contractor, provider type, or individual provider. For example, if I were trying to find out how many times a certain service had been billed in a state, I could obtain that information through the HCIS database. As a result, audits or reviews can be focused, rapidly and inexpensively, on a particular level. HCFA will continue to refine the HCIS which has been particularly helpful in providing rapid access to beneficiary and provider utilization data.

Statistical Analysis Contractor—HCFA is procuring new statistical analysis contractors who will provide comprehensive ongoing analysis of trends, utilization rates, billing patterns, referral patterns and related information. These contracts will be modeled after our successful work with Palmetto Government Benefits Administrator, Inc., the statistical analysis contractor who has supported our four Durable Medical Equipment Regional Contractors (DMERCs) in detecting specific areas of fraudulent behavior. As an example, through their analysis the contractor has identified fraudulent billing practices for nebulizers and related drugs, and many abusive practices for incontinence supplies, surgical dressings, parenteral & enteral nutrition and urological supplies.

We estimate the DMERCs have made changes in their payment policies that have saved the Medicare program in excess of \$200 million. They have also used this data to trigger provider reviews, support fraud investigations, and target enrollment verification activities.

We hope to have a statistical analysis contractor in place this year. We published a proposed regulation on March 28, 1998 outlining parameters for hiring this and other special program integrity contractors.

MEDICARE ANTI-FRAUD INITIATIVES

The Clinton Administration has focused unprecedented attention on the fight against fraud and abuse, and we continue to step up these efforts. These actions complement our CFO Audit corrective actions and help in the effort to stop improper payments, even though many are not reflected in this year's OIG audit report.

Our Medicare Integrity Program system of payment safeguards identifies and investigates suspicious claims throughout Medicare, and ensures that Medicare does not pay claims that other insurers should pay. These safeguards comprise a comprehensive system which attempts to identify improper claims before they are paid, to prevent the need to "pay and chase." HCFA's current strategy for program integrity focuses on prevention and early detection. Activities include: Medicare Secondary Payer, medical review, cost report audits and anti-fraud activities. These safeguards return \$17 for every \$1 spent, and saved \$7.6 billion in FY 1997 by prevent-

ing inappropriate payments through audits, medical reviews and making sure that Medicare does not pay for claims owed by private insurers.

Actions undertaken since the close of the FY 1997 CFO audit addressing durable medical equipment fraud and abuse include:

Expanded On-Site Visits—Visits by Medicare staff as part of Operation Restore Trust and studies by the HHS Inspector General show that many purported DME suppliers have only mail drops and no actual offices. Site visits to two thousand suppliers in five states with the most suspected DME fraud problems resulted in 650 suppliers being ejected or rejected by Medicare in FY 1997. HCFA is expanding site visits for DME suppliers nationwide this year.

Additional Standards for DME Suppliers—Medicare proposed a regulation on January 20 to make it more difficult for unscrupulous DME suppliers to enter Medicare and to strengthen enforcement against such suppliers. Among the new supplier requirements are:

- a surety bond of at least \$50,000,
- a ban on DME telemarketing and a requirement for a physical location with working business phone at that location,
- a prohibition on reassigning supplier numbers, and
- criminal and civil sanctions for false information on billing number applications.

Other Medicare actions to assure that DME suppliers are legitimate include:

- requiring periodic training on billing procedures for new and existing suppliers,
- eliminating 36,000 supplier billing numbers that had not been used for at least one year, eliminating the chance they will be exploited by scam operators,
- modifying the DME application form to obtain additional information about prospective DME suppliers, and
- seeking authority to charge all applicants an application fee that will help us fund increased enforcement efforts.

Home Health Initiatives—Several actions have been taken to fight home health waste, fraud and abuse. On September 15, 1997 the President announced a moratorium on new home health agencies (HHAs) until Medicare could implement a range of new rules and management tools that enhance oversight of HHAs and ensure that new Medicare home health agencies are not “fly-by-night” or low quality providers. The moratorium was lifted earlier this year with the publication of a regulation requiring all HHAs that participate in Medicare to:

- obtain a surety bond of at least \$50,000, and
 - have enough capital to fund operations for the first three months.
- In addition, we have taken administrative steps to require HHAs to:
- reveal “related business interests” that can be the conduit for fraudulent and abusive activities, and
 - serve at least 10 patients before they are admitted to the Medicare program so that their quality of care can be reviewed.

We believe initiatives we have taken are already impacting home health spending. We believe it is no coincidence that Medicare spending growth for home health care has slowed to just 5.4 percent in FY 1997 from rates that had exceeded 25 percent a year.

Later this year Medicare will issue regulations to require HHAs to re-enroll every three years, which will help us weed out problem providers. And the President has proposed assessing a fee on providers so we can do more audits that help ensure that Medicare only pays appropriate provider costs.

Recent Laws and Legislative Proposals

Thanks to the work of these committees and this Congress we now have more tools we need to fight fraud and abuse, many of which are not reflected in this year’s OIG audit. These tools from the Balanced Budget Act let us:

- exclude providers convicted of felonies or health related crimes;
- levy new civil monetary penalties on hospitals who contract with providers who have been excluded from Medicare;
- levy civil monetary penalties on providers who take kickbacks;
- require provider applicants to provide Social Security numbers and employer identification numbers so we can check the applicant histories; and
- tighten eligibility for home health services so providers can no longer game the system by certifying that a patient is eligible for home health service simply because they need blood drawn.

The Health Insurance Portability and Accountability Act also for the first time created a stable source of funding for fraud control, which in FY 1998 will total almost \$120 million. It also gave us authority to contract with special program integrity contractors.

Through additional tools provided in the Balanced Budget Act, new anti-fraud initiatives and our corrective action plan, I believe HCFA will continue to take steps in the right direction to reduce the national error rate of improper claims identified in the CFO Audit.

President Clinton's budget includes several proposals to continue our success in fighting health care fraud, waste, and abuse. These measures would save an additional \$2 billion in health care expenditures over five years, and help pay for the expansion of Medicare eligibility to the near-elderly. The proposals include:

- more subpoena and injunction authority;
- penalties for physicians who falsely certify that an individual meets Medicare requirements;
- eliminating fraudulent use of bankruptcy protections that allow providers engaging in fraudulent practices to avoid paying penalties and returning the money they owe;
- establishing fines for providers who pay kickbacks to induce referrals;
- stopping providers from pretending to furnish partial hospitalization services in a beneficiary's home or in an inpatient or residential setting.
- and user fees to fund important activities such as audits, reviews, provider enrollment, and survey and certification efforts.

Obviously, the President's budget proposals and the Balanced Budget Act provisions have not been implemented and are not reflected in the OIG audit report. We are confident that those actions will be reflected in next year's OIG report.

FINANCIAL STATEMENTS

The other function of the CFO Audit is to determine whether HCFA's internal accounting mechanisms are in order. In public accounting terms, the purpose of an audit is to permit the auditors to issue a report as to whether the financial statements are presented fairly and in conformity with generally accepted accounting principles. There are four types of audit reports: 1) an unqualified opinion, which means the financial statements are fairly presented; 2) a qualified opinion, which means the financial statements are fairly presented except for the effects of a matter or matters as described in the auditor's report; 3) an adverse opinion, which means the financial statements are not presented fairly; and, (4) a disclaimer of opinion, which states that the auditor does not express an opinion on the financial statements and gives all the substantive reasons for the disclaimer.

I am very pleased to say that HCFA has resolved two major financial statement shortcomings on which we received a disclaimer in last year's audit. The Medicare accounts payables estimating methodology was successfully revised, and the Supplemental Medical Insurance premium withholding by the Social Security Administration was successfully audited.

Accounts payable (\$27.4 billion) represents costs incurred but not paid as of the end of the fiscal year. In previous years, the payable was a byproduct of the trust fund projections. With advice from a national public accounting firm, HCFA developed a revised methodology, collected data, and this allowed the OIG to estimate a revised Medicare payable.

Also, importantly, we have gotten our books in order with the Social Security Administration. The majority of Supplemental Medical Insurance premiums (\$19.1 billion) are withheld by the Social Security Administration (SSA) from beneficiaries' Social Security checks and transferred to the Part B trust fund. This year auditing was possible at both the Social Security Administration and HCFA.

The FY 1997 OIG audit does highlight areas where HCFA must focus attention in financial reporting. These include constructing a uniform audit trail for Medicare and Medicaid accounts receivable, developing an auditing methodology for the cost report settlement process, and establishing internal controls for Medicare liabilities, financial management controls and electronic data processing controls.

Medicare/Medicaid Accounts Receivable

Of HCFA's \$225 billion annual expenditures, the OIG disclaimed a total of \$2.5 billion for Medicare and \$450 million for Medicaid. The auditors could not be sure the receivable number was correct due to the lack of general ledgers and other documentation at most Medicare contractors. Concerns were also expressed about internal controls. Because states' use different accounting systems, their reporting of receivables is inconsistent.

HCFA's long range goal is to standardize contractors' claims processing systems making it possible to have an integrated accounting system. However, these require extensive system changes which will not be possible with the resources currently allocated to making the agency and its contractors Year 2000 compliant. Our short

term corrective actions will focus on using the contractors' existing subsidiary systems to improve the quality of data, and to identify and document the audit trails necessary to support and validate the data reported to HCFA.

Cost Report Settlements

The OIG was unable to determine an appropriate way to audit the cost settlement process, in which our contractors audit cost reports submitted by providers. Desk reviews are done for all cost reports, and some providers' cost reports are audited using either a full or limited scope approach.

HCFA's approach has been to focus our limited audit resources on those providers that have a greater potential for overpayment in order to recover misspent Medicare funds and to provide a sentinel effect on all providers. The OIG has not challenged the quality of the current process and, in fact, has recognized its high cost-savings ratio.

Government audit standards would allow the OIG to rely on HCFA's provider audit process if it were based upon a methodology that would select a representative sample of cost reports to be audited. Presently, it is not possible for the OIG to review a sub-sample of the HCFA audits and develop a statistically valid national error rate, or to ensure that the number reported on the financial statement is "fairly represented" as an accurate reflection of HCFA's liability.

HCFA plans to work with the OIG further to address this. However, it is important to note that the advent of more Medicare prospective payment systems will greatly reduce cost reporting.

Internal Controls

Internal controls provide reasonable assurance that transactions are properly recorded and accounted for, safeguarded against loss, and in compliance with laws and regulations. They include such things as separation of duties, delegation of authorities, and access to and accountability for resources. For example, HCFA is updating instructions for financial reporting, as well requiring that components develop internal operating procedures that clearly identify controls.

For electronic data processing (EDP), HCFA has introduced a systems security initiative to aggressively address vulnerabilities found through the OIG's and our own reviews. Our goal is to be able to maintain the tightest security as the business environment in which we operate changes, and to integrate security into every aspect of our information technology management activities.

CONCLUSION

While there is work to be done for HCFA to improve the results of the CFO audit, I am pleased with the progress the agency has made in one year in both reducing the estimate of improper payments and getting its financial statements in order. We have made tremendous strides, and with your help and support, we will continue to make needed improvements that will ensure that the Medicare program is well managed, financially sound, and free from waste, fraud, and abuse.

Mr. BARTON. Thank you, and your entire written statement will be included in the record.

We recognized questioners in order of appearance. Mr. Bilirakis was the first one in the hearing room. We recognize them in order of seniority. Mr. Bilirakis is the senior member in the hearing room, and we recognize them in order of the importance of the subcommittee, and his Health and Environment Subcommittee is the most important subcommittee of the Commerce Committee that is here. So for those three reasons, we are going to recognize Mr. Bilirakis for the first 10 minutes of questions.

Mr. BILIRAKIS. I appreciate that, Mr. Chairman, and after that, I would yield to Dr. Norwood, because he has an important hearing he must attend.

Mr. BARTON. So he owes you big time.

Mr. NORWOOD. Don't worry, he'll collect, too. Thank you, Mr. Chairman, both of you. I appreciate this opportunity. My first question is, who prepared these documents?

Ms. BROWN. The Office of Inspector General.

Mr. NORWOOD. Would you please prepare for this committee a third document which will blend those two? For example, you say physician, 5.9. Lay out the percent for us on the type of error, all the way down, for the physician and for the inpatient hospital. Could you do that, please, ma'am?

Ms. BROWN. Yes, we will.

[The information referred to follows:]

Types of Errors (dollars in millions)									
Type of Provider	Lack of medical necessity	Insufficient documentation	Incorrect coding	Documents not provided due to extenuating circumstances	No documentation	Non-covered or not allowable	All other errors	Total	Percentage of improper payments ¹
Physician	\$376	\$2,415	\$1,698	560	\$178	\$387	\$291	\$5,905	29.11%
Inpatient PPS	2,319	460	1,001	264		17		4,061	20.02%
HHA	2,484	68				1		2,553	12.59%
Outpatient	435	1,478	8		2	32	2	1,957	9.65%
DME	100	80	218	1,009	498	13	1	1,939	9.56%
Transportation	397	3	8	714	18	2	(1) ²	1,141	5.63%
Subtotal	\$6,111	\$4,504	\$2,933	\$2,547	\$696	\$472	\$293	\$17,556	86.56%
SNF	471	145				13		629	3.10%
Hospice	129	154			138			621	3.06%
End Stage Renal Disease		81	4	375				460	2.27%
Inpatient Non-PPS	448							448	2.21%
Laboratory	76	230	23	19	16	45	10	419	2.07%
Ambulatory Surgery	45	89	15					149	.73%
Total	\$7,480	\$5,203	\$2,975	\$2,941	\$850	\$530	\$303	\$20,282	100.00%
Percentage of Improper Payments	36.88%	25.65%	14.67%	14.50%	4.20%	2.61%	1.49%		

¹ Cases in which the providers were under investigation, and we were prohibited from requesting medical records. Because we could not test the validity of these claims, we considered them invalid for determining whether total fee-for-service expenditures were fairly presented. It should be noted these claims could be valid or erroneous (including fraudulent).

² Percentage of the overall estimate of \$20.282 billion by the type of claim.

³ Negative dollars represent claims for which the number of services billed was less than the number of services provided.

⁴ The range of improper payments at the 95 percent confidence level is \$12.129 billion to \$28.434 billion. Each dollar estimate is computed consistent with the sampling methodology. The sum of all dollars equals the overall estimate of \$20.282 billion.

Mr. NORWOOD. Second, let me ask you to include when we are looking for error that amount of error that is occurring through the payment practices of HCFA through their contractors?

Ms. BROWN. Sir, it was about 99 percent correct based on what the contractor received in the claim.

Mr. NORWOOD. The contractors got it right?

Ms. BROWN. The contractors got it right. The only way——

Mr. NORWOOD. Then tell me how you can pay for noncovered services.

Ms. BROWN. Well, because the documentation sent to the contractors was either fraudulently or mistakenly coded wrong, so there was no way we would have been able to——

Mr. NORWOOD. Why wouldn't that fall under incorrect coding then.

Ms. BROWN. Well, incorrect coding means the code for the particular service given. Providers learn what kind of claim codes get through the system, and they can submit those codes. The only way we could identify this is by going back to the patient records and having medical people examine the patient's records and see if what was submitted in the claim was proper based on the patient's record.

Mr. NORWOOD. If it is not their job to examine the claim to see if it needs to be paid, what is the job of the contractor? They aren't doing that. I know that, and I hope you do too. They are checking, spot checking claims from time to time; therefore, there is a great deal of payment incorrectly being made because your contractors aren't doing the job, and that is the only way I can understand how you would pay for an unallowable service. You did it, you didn't mean to, the contractor didn't pick up on it.

Mr. VENGRIN. Explicitly, the bulk of those charges were for physicals and on the claim, the physician——

Mr. NORWOOD. The bulk of which charges?

Mr. VENGRIN. The noncovered services that you are speaking of, sir. Most of those on the claim, the physician would bill, for example, an intermediate visit? And there is no evidence on that claim that it was for an annual physical not covered by Medicare. It was not until we went into the medical records and obtained the support for that that we found that type of documentation.

Mr. NORWOOD. You cover an annual physical? You will pay for that?

Mr. VENGRIN. Typically they do not.

Mr. NORWOOD. Do not. Do you pay for a physical prior to the preparation for a patient for surgery?

Ms. DEPARLE. If it is medically necessary, sir, we do.

Mr. NORWOOD. Who decides that, the doctor or somebody else?

Ms. DEPARLE. The doctor.

Mr. NORWOOD. The doctor. Besides that, let me ask you if you have with you, madam, the correct coding initiative. Did you bring that with you?

Ms. DEPARLE. No, sir, I didn't.

Mr. NORWOOD. How high is that? If you measured it, how many pages in that thing?

Ms. DEPARLE. I don't know, sir. I can get an answer for you. It is 90——

Mr. NORWOOD. Can anybody guess? Can any of you guys guess?

Ms. KANOF. In terms of paper?

Mr. NORWOOD. Yeah, how many pages in that?

Ms. KANOF. So big.

Mr. NORWOOD. A foot high?

Ms. KANOF. I think.

Mr. NORWOOD. Has that been distributed to the providers yet?

Ms. KANOF. Yes.

Mr. NORWOOD. It has.

Mr. BARTON. The witness that has been sworn is Ms. DeParle.

Mr. NORWOOD. The document we are told is about a foot high. Could you agree with that?

Ms. DEPARLE. Sir, from what I understand, the Correct Coding Initiative is a software program that has edits, and I think there are about 93,000 edits, so I suppose if you put them on paper it would be a lot of pages. I don't know how many pages it is.

Mr. NORWOOD. It is a lot, isn't it? How long have our providers had that?

Ms. DEPARLE. Well, it was implemented I believe 2 years ago and I would assume our providers—I know it was provided to the physician community and I assume they have had it at least a year, because no one has brought it up to me since I have been there and I have been there about 6 or 7 months now.

Mr. NORWOOD. Do you know and realize, and I am sure you do, that the cost of documentation to satisfy the Federal Government is generally longer than anyone else's documentation, and it requires a great deal of time from staff to document, according to your needs, in order for people to be paid? Would you agree with that?

Ms. DEPARLE. Yes, sir, I do. I have spoken with physicians about it, but if I could make one point about your point. The kind of documentation errors that I believe that the Inspector General found here, and I guess actually she should speak to that, but I asked that very question when they did this presentation for me, because I had been with some doctors who are telling me just what you are saying, and I said well, is this that they didn't dictate enough notes for the file or what are we talking about here? They told me, and they have given some examples in their report, that the kind of thing they were seeing in the category of "no documentation" or "insufficient" was they would repeatedly ask the physician whose claims were in that sample, you know, give us some documentation for this claim, and when the paper came in, it looked okay, but they were trying to look behind it and they would get something back like a piece of paper that said "stable" on it. So I understand your concern and I am concerned about that as well, but I think what they are speaking to is something that is really almost non-existent.

Mr. NORWOOD. Well, my real concern is about the documentation. I have no doubt in my mind you ask for too much, but that is beside the point.

My concern is that the cost of that requirement is not shared by you at all; it is simply passed on. That probably has as much to do with the difficulty in documentation as any other part, which would then go to the contractors, who have no incentive to check

either. As I understand it from talking to them, they simply aren't paid enough in order to check the documents which in the end leads to the problems that we have. And I would like—my personal opinion is that a big part of this problem isn't just the providers of health care out there, but it is the largesse and inefficiency that operations that may not could ever do better because of the largesse.

Mr. BILIRAKIS. Will the gentleman yield?

Mr. NORWOOD. Yes, sir, of course.

Mr. BILIRAKIS. Before you get away from the medical necessity portion, and I would ask this question of both of you, who determines lack of medical necessity? Does the Inspector General determine the figure that 37 percent of the improper payments are made as a result of lack of medical necessity?

Ms. BROWN. We have medical people reviewing the documentation to see whether it is a medically necessary service that is being performed, and they make that determination. We accept their analysis.

Mr. BILIRAKIS. All right. So they made that determination on the basis of a certain percentage, and then you extrapolated that out, and came up with the 37 percent?

Ms. BROWN. Yes. That was 37 percent of those that we consider to have in error.

If I could comment on the documentation, the American Medical Association is the one who determines what kind of medical documentation is required for patients' files, and HCFA accepts that view. Then we look behind the claim that came in to see whether indeed that documentation exists in the file that will show what services were performed on a certain patient.

Mr. NORWOOD. Are you saying to Mr. Bilirakis that the medical necessity decision is made by medical personnel in your office or in HCFA's office?

Mr. VENGRIN. No, sir. These are people at the Medicare contractors. These are physicians. On the hospital visits, these will be the peer review organizations. These are doctors making these decisions.

Mr. NORWOOD. And they work for insurance companies you are calling contractors, or administrative type people?

Mr. VENGRIN. That is correct.

Mr. BILIRAKIS. But those people have already approved the payment of those claims, have they not?

Mr. VENGRIN. These claims have indeed been paid. That is why we examined them. They are on the financial statements.

Mr. BILIRAKIS. But it is those same people that will come back and take another look at it and determine that the payment was improper.

Mr. VENGRIN. There is a big difference, sir. When they processed those claims initially, they went through an edit process. We did not obtain the medical reviews until after those claims were processed.

Mr. NORWOOD. When the medical necessity decision is made in Pennsylvania for a patient being treated perhaps in Maryland, how often does the physician who is deciding upon medical necessity ever touch the patient?

Mr. BARTON. That will have to be the last question.

Mr. NORWOOD. That is a shame. How often do they examine the patient when they say, oh, no, that is not medically necessary?

Ms. DEPARLE. They don't look at them at all, sir. Can I explain one thing? I want to be sure that it is clear that we are talking about two separate processes here. One is the process that normally happens, and I understand you have some concerns about that, and that is when the claims come in to our contractors from a physician, and it is a piece of paper where they checked off things, the contractor looks at that and under the way the process works right now, they have 14 days, if it looks okay, to pay the claim, and that is what happens. Unless there is a medical review later or an audit of that claim or that provider, then we would not know that things might fall into these categories. That is why we have stepped up the numbers of medical reviews and audits and those sorts of things. What the Inspector General did was they came in and they looked behind those claims that have been paid and they did those medical reviews, and they found where these errors are, and I guess the moral of that is—

Mr. BARTON. Mr. Green has a plane to catch and he wants to ask one or two questions, so we can obviously submit this.

Mr. NORWOOD. Mr. Chairman, hundreds of questions I would like to submit.

Mr. BARTON. Okay. The gentleman from Houston, Texas, Mr. Green.

Mr. GREEN. Thank you, Mr. Chairman. My line of questioning will follow up on what both Chairman Bilirakis and my friend from Georgia talked about. Ms. DeParle, the United States pays these financial intermediaries for processing the work for paying the claims, and is there—we pay them a substantial sum obviously to administer it, like some of our private businesses pay intermediaries to administer their programs. And we pay these financial intermediaries to process the claims because they have that expertise, and I know in Texas it is Blue Cross, for example, and it is different entities around the country.

In addition to conducting business for the government, these fiscal intermediaries also have their own insurance companies that they do. Again, not picking on Blue Cross, that is the one I am familiar with because of the Texas experience. The error rate between these fiscal intermediaries that process their own claims versus the error rate that they process for HCFA, or to the Medicare program, have you been able to see if there is a difference in error rate between those two?

Ms. DEPARLE. No, sir. And at this point, as you know, the law requires us to use these insurance companies to process the claims, and there are certain requirements I was trying to explain with Representative Norwood—that they are required to pay claims within 14 days if they look okay, and as the Inspector General said, a lot of them do look okay. It is only when you look behind them that we find these problems. We don't have information about the contractors' individual error rates. There are about 70 contractors, and we have actually, Joe Vengrin and I and June, discussed this, whether it would make sense to get an error rate on each contractor, and the problem is, Joe may remember the numbers, but it

would take, looking at millions of claims to get a statistically valid error rate on a contractor. So we don't know what their error rates are.

Mr. GREEN. You only estimated on this 8,000 claims?

Ms. DEPARLE. We looked at 8,000 claims.

Mr. GREEN. Why can't you use the same methodology for looking at the contractors that you use for looking at what you are reporting to us today?

Mr. VENGRIN. It would be most difficult to go down to a contractor; you would have to quadruple the sample size or probably need a multiplier of about 50 to get the error rate by contractor. More—over—

Mr. GREEN. Let me, because I have to leave too. I understand that, but I am concerned that we have \$177 billion of, and we are using this same methodology for saying that we have X amount of money for waste, fraud and abuse, which is almost more than half of it may be for documentation questions. But again, using the same methodology, what I am trying to say is that are we doing such a bad job on the Federal level because of our law as compared to the private sector? And that ought to be able to get to that without having to multiply it by 50 times unless you want to multiply this methodology by 50 times and maybe we could get a better number.

Ms. DEPARLE. We can discuss this some more. It is something that I was interested in, and the numbers that Joe gave me about how much this would cost were awfully big, but it is certainly something I can discuss with you. On the private sector side though, sir, based on what I have learned from talking with them and from talking to experts in this field, many folks feel that we are doing a better job than the private sector, and the important thing is that because of this law, we have to analyze it, and we know what our error rate is. I think that is an important step, because then we can set goals and try to do something about it. The private sector doesn't do that.

Mr. GREEN. Well, isn't it true that the fiscal intermediaries only audit about 2 percent of the Medicare? Do you know if the 2 percent is the same they audit for their own private sector business, for example, the Federal Government's insurance program that a lot of them are also contractors for that or providers of?

Ms. DEPARLE. I believe the audits, sir, are around 10 percent. We audit about 10 percent of our claims.

Mr. GREEN. Okay. Our information is 2 percent, but you might check on that.

Thank you, Mr. Chairman.

I yield the balance of my time to my colleague from Ohio.

Mr. BARTON. The gentleman yields the balance of his time to Mr. Kucinich.

Mr. KUCINICH. Thank you very much, Mr. Chairman, appreciate it.

I thought earlier the point Mr. Norwood was making was very important because we are talking about financial intermediaries here, private insurance companies. And they appear to be a large part of the problem, because there needs to be an incentive for

intermediaries. It seems to me there needs to be an incentive for intermediaries to do audits before paying your claim.

I would like to know, Ms. DeParle, are there financial incentives for financial intermediaries to pay claims and not to ask too many questions?

Ms. DEPARLE. Yes, there are, because the way this system is set up right now, they are paid to process claims quickly. And we have not had the amount of funding that we need to devote to audits and to medical reviews. We need to increase that side and probably look at the other side to make sure that they are not just getting claims out the door.

Mr. KUCINICH. They pay claims quickly. So what happens the quicker they pay the claims? What happens for them?

Ms. DEPARLE. They get paid for that. They have to meet certain standards. And as Ms. Brown indicated, the claims that come in to them look okay, it is only when you go behind the claim that you see the problems.

Mr. KUCINICH. Let us slow this down a bit. They pay the claims quickly, don't ask too many questions. But if you started asking questions, it slows down their processing, and then they don't make as much money.

Ms. DEPARLE. That is true. Although if there are problems with the claims, they are supposed to investigate them. But we don't have a problem with claims being paid quickly.

Mr. KUCINICH. I understand that.

Ms. DEPARLE. That is the point you are making.

Mr. KUCINICH. But there is a problem with sometimes not enough questions being asked.

Ms. DEPARLE. That's correct. And that's why—

Mr. KUCINICH. So reconcile that for me.

Ms. DEPARLE. Well, we need to put more emphasis—and this is a conversation that Ms. Brown and I have been having—we need to put more emphasis on making sure that the contractors have the funding to do audits and medical reviews of claims. We are increasing that. We have increased it this year through the Medicare Integrity Program. But we need to do even more.

With our claims volume being as high as you noted, and Chairman Barton noted, and others have noted, we need to do more.

Mr. KUCINICH. Have you discharged any contractors because they are apparently not asking enough questions?

Ms. DEPARLE. I don't believe so. We have had some contractors leave the business over the past year, and there have been some problems, but I don't believe we have discharged anyone for that reason.

Mr. KUCINICH. Would it be unfair to say in this system you are describing that you are throwing money at the private contractors?

Ms. DEPARLE. Well, I think what we are seeing here is the way this system was set up, we were required to pay insurance companies to process these claims, and there was a big premium put on getting the claims through quickly.

I think what you are now seeing, and what we are wrestling with ourselves, is should we change that paradigm. And that is something we are looking at as well.

Mr. KUCINICH. Let's talk about this now. What percentage of claims do the private contractors actually audit?

Ms. DEPARLE. I believe it's around 10 percent, sir.

Mr. KUCINICH. Is there a distinction between an audit and a medical review?

Ms. DEPARLE. Yes. A medical review is more intense, generally. And there are desk audits and also site audits. So there are different types of audits.

Mr. KUCINICH. Let me ask the Inspector General, is there a distinction between the audit that she is talking about with respect to the medical contractors and the kind of audit that you do?

Mr. VENGRIN. Yes.

Ms. BROWN. Yes.

Mr. KUCINICH. Is their medical review closer to the kind of audit you do?

Mr. VENGRIN. They do both. They do what they call screens, and they do focused medical reviews.

Mr. BARTON. Will the gentleman suspend?

Those documents in the back of the room are going to be there after the hearing is over. I think we owe the courtesy to the questioner and to the respondents for the audience to be seated. We are not going to take the documents away, so they will be there.

Mr. Kucinich.

Mr. KUCINICH. Thank you very much, Mr. Chairman.

Please.

Mr. VENGRIN. The Administrator is correct. They do both, sir. They do a focused medical review, and they do automated computerized screens of the claim. That is what is referred to at 9 or 10 percent. Ours included a full-blown medical review on those claims. They were more geared to the focused medical reviews.

Mr. KUCINICH. Tell me for a moment about how much of the review of the private contracting do you get into?

Mr. VENGRIN. Could you expand your question, sir?

Mr. KUCINICH. We are talking here about the private contractors—

Mr. VENGRIN. Yes, sir.

Mr. KUCINICH. [continuing] and the auditing they do. How much checking in of the private contractors do you do? Do you check them that much?

Mr. VENGRIN. Yes. We have reviewed all the internal control structure at the contractor level. But I would like to clarify, the majority of these claims, again on the surface, the physician and medical individuals bill a code. You don't find this type of documentation until you get into—

Mr. KUCINICH. I will wrap up this part so it will go back to Mr. Horn, but one quick follow-up. Why doesn't the private contractor go beneath the surface?

Mr. VENGRIN. Again, sir, we gave an example. The bill is for an intermediate visit, but, in fact, they performed a full-blown medical examination, an annual physical. That was not on the claim form. The contractor wouldn't have fleshed that thing out when they processed it initially to review it.

Mr. KUCINICH. I thank the gentleman and I thank the Chair, and we will get back to that. Thank you.

Mr. BARTON. You will have 10 minutes of your own time.

We recognize the distinguished chairman of the Government Management, Information, and Technology Subcommittee of the Government Reform and Oversight Committee, Mr. Horn, for 10 minutes.

Mr. HORN. Thank you very much, Chairman Barton, and I appreciate having all of you here. I know you are doing a fine job.

I am going to first ask you, before getting into any details on the audit, just a couple of questions that have come to mind that I have always been curious about.

One is, I didn't know until this morning that a physical exam was not covered by Medicare. Is that by congressional language?

Ms. DEPARLE. It is by the statute, the way it was written.

Mr. HORN. Back in 1965?

Ms. DEPARLE. Yes, sir.

Mr. HORN. That escaped me. I don't know how that escaped me.

Ms. DEPARLE. This year the Balanced Budget Act made some changes. It did not cover routine physical exams, but you started covering some preventive treatments. But under the old Medicare statute, it requires us to only cover things reasonable and necessary to treat an illness, so someone really has to be sick.

Mr. HORN. I would think since we all believe in preventive medicine that we would encourage physical exams.

Ms. DEPARLE. They have not been covered. And as I said, we did make some changes in the Balanced Budget Act, so we are making changes in that direction.

Mr. HORN. Are you moving toward giving everyone at least one physical exam annually?

Ms. DEPARLE. No, we are not. That is not part of the statute, but it is something I would like to discuss with you, because I have actually thought myself that that might be useful, although the doctors that I have spoken with have said that some of these other things are more useful to them than a routine physical.

Mr. HORN. Well, I am glad you brought that up. We learn something every day.

Now, of the various categories of medicine, doctors, hospitals, home care, and so forth, which area causes you the most difficulty when it comes to fraudulent records? And I would ask both of you that question.

Ms. BROWN. Well, the highest percentage of improper payments in this audit was with the physicians.

Mr. HORN. Home care is in there after the hospitals?

Ms. BROWN. Yes.

Mr. HORN. I have heard a lot of complaints about home care, where people don't put in a full hour, but they bill for that, and they might have been there for 10 minutes. I am told there is a 1-800 number.

I don't know if that is your operation or not, but I thought it was a great idea that they check in when they get to the home and they check in when they leave, which is one way of at least what we would call, I guess, when you talk about bar association education or doctor education, "see time." Doesn't mean you have done anything constructive, but at least you know you are there.

What do you think of that? Is that a problem?

Ms. BROWN. Home health care has been a problem area. It is a problem because it grew very, very quickly, and visits didn't necessarily get made at all, let alone a short visit.

I don't think we have focused on things where the visit was half the length of time as much as when visits weren't made or where they weren't necessary because the person wasn't home-bound and didn't qualify.

Mr. HORN. Interesting. Any comment on that?

Ms. DEPARLE. Well, I can't resist. I'm an optimist. I think we can make this better. And I'm not saying that blindly, because I think we are taking some actions to make it better.

One area where I found some reason to be optimistic is in home health. It has been a major problem, but we have taken actions in conjunction with the Inspector General over the last 2 or 3 years to crack down on it, and with Congress' support.

And in speaking with Mr. Vengrin about the analysis of the audit, it appears that in the fourth quarter of 1997, things started to slow down. The error rate in home health at the contractor they were reviewing, which is one of the largest ones, looked better. So I am hoping some of the things we have been doing are beginning to have an effect there, but it has been a major problem.

Mr. HORN. Back in 1965, I did strongly back home health care. I believe in it. I think it's better for the senior citizen. But we only knew of one city at that time, Detroit, that had a decent program. So it is rather fascinating what the growth of that area has been.

Ms. BROWN. We did a report recently, sir, and looked at home health care in four different States, and we found a 40 percent rate of visits that should have been made or paid for where either the visit wasn't made, or the person wasn't qualified to get that visit, or there was some error in it. Those States were California, New York, Texas and Illinois.

Mr. HORN. The big ones.

Ms. BROWN. That's right.

Mr. HORN. I happen to have a Medicare card. I pay faithfully in my doctor's service bill of, I don't know, \$500 a quarter, something like that. And, of course, it is never used because I'm a Federal employee, and that is what is charged against and not Medicare.

How many people are in a similar situation, and how many billions of dollars does that work up to, where we are putting money in Medicare and we are eligible for it, but we never use it because we are covered by other health plans? How much is at stake here, in billions? Do we know that?

Ms. DEPARLE. I don't know that, but I would like to get back to you for the record.

Mr. HORN. Would you? We would appreciate it.

[The following was received for the record.]

Our 1995 Medicare Current Beneficiary Survey suggests that about 1 million of the 37.5 million beneficiaries enrolled at that time, or 2.6 percent, had received Medicare-covered services but had not billed Medicare, suggesting that they may have another, primary insurer. Efforts we take to make sure we not pay bills that should be paid by beneficiaries' primary insurers saved approximately \$3.4 billion in 1997.

Mr. HORN. Collections interest me, since I'm the author of the Debt Collection Act a few years ago. What kind of collection system

do we have in Medicare to collect moneys that are owed the government, either because they have been miscoded or whatever? How do we deal with that?

And I would like both your comments on that.

Mr. VENGRIN. Chairman Horn, the Inspector General has, for 3 years now, raised concerns about this receivable issue. They do have a process at the contractor level to try to recoup these overpayments, but in the last 2 years, as you know, we have had to qualify our opinion because we go out there and test these systems out, and, in one case, one system has \$10 million; in another case, another system has \$12 million. The auditors really can't get comfortable with their process.

Health Care Financing is going to have an aggressive program this year to see if we can't get to the bottom of this problem since we have now reported it for several years.

Mr. HORN. Now, do you decentralize this as, say, the Department of Education does to a region or an area with its own system of collection?

Mr. VENGRIN. Yes, sir.

Ms. DEPARLE. Contractors do it, just like they pay the claims.

Mr. HORN. That is their responsibility?

Ms. DEPARLE. Yes.

Mr. HORN. Are these private contractors or government employees?

Ms. DEPARLE. They are all private contractors. Under the law, as you may remember, it was stipulated that we would use these contractors that would be insurance companies that would pay the claims. So that is who does it.

Mr. HORN. Now, do the insurance companies use private collectors, or how do they handle the actual collection?

Mr. VENGRIN. Usually through offset claims coming in, sir.

Mr. HORN. Okay. Offset against future?

Mr. VENGRIN. Yes, sir.

Ms. DEPARLE. And one problem we have on that is we have had some problems in areas like home health, with providers going bankrupt or skipping out, and it was hard for us to get at them. And we may need to discuss with you some changes that would need to be made there.

Mr. HORN. That, obviously, concerns me. That is what started us on this, when the Internal Revenue Service said they had written off \$100 billion between 1990 and 1995. And needless to say, we were unhappy, feeling that is a national scandal. What is the write-off in Medicare?

Ms. DEPARLE. I don't know that, sir, but I can get that for you for the record.

Mr. HORN. Could we?

[The following was received for the record:]

For FY 1997, the total write-off of overpayments that were not recouped by HCFA was approximately \$59 million: \$29 million for Part A and \$30 million for Part B. Under Part A, about 50% of overpayments that HCFA is unable to collect are in home health.

Mr. HORN. Does the Inspector General have any thoughts on that?

Ms. BROWN. I don't have the amount that has been written off. There wasn't detail to support the total amount that was counted as accounts receivable; so we couldn't go back and really add up the specific claims and come to that figure. We are worried about the accuracy of them.

As far as the claims process goes, though, one relevant thing, I think, is that 95 percent of those payments in our sample last year that were identified as improper payments have been recovered by HCFA through their contractors.

Mr. HORN. How much did that amount to?

Ms. DEPARLE. It is around \$400,000.

Mr. HORN. That is all, nationwide?

Ms. DEPARLE. Remember, the way this is done, it is a statistical sample. So that is what is extrapolated to the \$23 billion; but itself, it only represented \$400,000.

Mr. HORN. But what does that extrapolate to in terms of billions of dollars?

Ms. BROWN. Well, unfortunately, of course, those projected improper payments that weren't in the sample were not specifically identified, so those have not been collected.

Mr. HORN. Well, are there recommendations the Inspector General has made on collections at all, even though it is through contractors already?

Ms. BROWN. Yes, we have. There are several things we have worked out with HCFA, and they are implementing these new controls.

Mr. HORN. They are implementing them. How far along are we on implementation?

Ms. DEPARLE. This is the second year it has been an area of concern to the Inspector General, so we have not solved the problem, but it is one of the things we will be the most aggressive about next year.

Mr. HORN. And that will spread beyond the \$400,000, which is a drop in the bucket?

Ms. DEPARLE. Yes. But my goal, again this year, is to begin immediately collecting these dollars. Again, though, because it is a statistical sample, it won't be the entire \$20 billion; it will just be those claims. But as we get better at this, I hope our collections will improve.

Mr. HORN. Well, beside offset, for the ones that are into bankruptcy or moving around, fly by-night operations of one sort or another, what are we doing to track those people down by some, say, identifier number that the IRS might use and you might use so we can get the money owed the taxpayers?

Ms. DEPARLE. We are doing a number of things. One thing is that last year Congress passed a requirement for surety bonds that will, we think, help us have sort of a filter before new providers get into the system. If they have to post a surety bond, a company will have to check them out and make sure they are a going concern, because that has been a problem. If they owe Medicare money, then we will have something to collect against.

We have a proposal up here again this year to try to do something about the situation where providers go bankrupt and leave

Medicare holding the bag, and we would like to work with you on that. So those are two things we are doing to try to address this.

Mr. HORN. Good. Thank you, Mr. Chairman.

The next round I will get to the more serious questions.

Mr. BARTON. Okay. The Chair is going to recognize Mr. Bilirakis for 10 minutes.

Mr. BILIRAKIS. Thank you very much, Mr. Chairman. I may not take all of that time. I appreciate the courtesy.

Now, you have indicated, Madam Administrator, that HCFA has collected about 95 percent of the claims of the overpayments from providers that have been made known to them.

Ms. DEPARLE. From last year's audit, yes.

Mr. BILIRAKIS. The Inspector General's audit?

Ms. DEPARLE. Yes, sir.

Mr. BILIRAKIS. Would you have a self-audit? In other words, if Inspector General were not auditing you, would you have known that there are excessive overpayments that you should be collecting?

Ms. DEPARLE. I think that there were some audit activities going on, but, no, sir, I don't think it was anything nearly as significant or as reliable a tool as what this CFO Act and the Government Management Reform Act did. That is why I think it is such a terrific tool.

As you said in the beginning of the hearing, it is not a pleasant thing to hear what your error rate is, but I also think it is terrific, though, that we know what our problems are, and now we can go about attacking them. So I don't think we would have known that if it had not been for this audit.

Mr. BILIRAKIS. We are talking about more than \$20 billion, apparently, that is wasted here. And yet, you referred to the user fees of the President's budget and your need for more money, but, we don't hear as much on how you are trying to correct the inadequacies and inefficiencies.

We are insisting on proper documentation from providers, when apparently 44 percent of the waste is attributed. We are going back to the providers, the magicians in our society, who we depend upon so very, very much, and who we are driving out of the business, I might add. And Dr. Norwood is over here saying this; a person who is not a medical provider is making that comment. And yet all of these problems take place.

In my opening statement, I referred to the NIH budget. How must NIH feel, that just a little more research and we may be coming up with something regarding Parkinson's, for instance, and some of these other illnesses. An extra \$1- or \$2- or \$3 billion might do wonders. How does NIH feel about so much of this money is going basically out the window at HCFA?

I talked about the medical necessity, I know how very strongly doctors feel about somebody in an ivory tower making the decisions on what is a medical necessity and what isn't. When you testified before my committee before, we have basically confirmed that people who never see the patient are making the determination of what is a medical necessity and what is not. You can't have those people see every one of those patients, obviously, but somehow that has to be worked out.

Now, the False Claims Act. Mr. Barton and I have probably placed more emphasis on waste, fraud and abuse in the first part of this Congress, and particularly in the last Congress, than any other Member of Congress. Joe and I haven't talked about the False Claims Act, so I'm not sure how he feels about that, but I think that we are concerned about justice and fairness.

You have heard these claims of overzealousness, particularly from the providing hospitals, and the misuse of the False Claims Act. Do you have any opinion about that? I'm going to ask both of you about that, but it may not be appropriate for you, Ms. Brown. If it isn't, you might speak up. Why don't we start off with you. Do you have any feeling about that?

Ms. BROWN. I think my office tries to be very careful in making any assessment on these institutions. We recognize that they are necessary in their community and made up, for the most part, of highly ethical, dedicated people. But the things that we have investigated, the 72-hour window, the PATH project and so on, we have tried to bend over backwards to make sure that the hospital had information either from the carrier or in their own records that showed what the procedures should be and that it was in violation of those procedures that were known to them.

Mr. BILIRAKIS. If the hospital has been advised by the contract carrier and has abided by the advice and the counseling they received from them should they be subject to the tremendous fines?

Ms. BROWN. If they have abided by those procedures, they are not subject to those fines.

Mr. BILIRAKIS. They are not subject to them?

Ms. BROWN. They are not, no.

Mr. BILIRAKIS. They tell us differently.

Ms. BROWN. If we find there are errors that they've made, which we would consider a normal rate of error, because some go in one direction and some go in the other, we offset those to make sure that they aren't accused in some way of a deliberate error when, in fact, it was a normal range of mistakes that people make. And hospitals such as Dartmouth did not have to pay anything, because theirs was—

Mr. BILIRAKIS. All right, but you are not speaking for the Justice Department.

Ms. BROWN. I can't speak for the Justice Department.

Mr. BILIRAKIS. Of course you can't. I realize that.

I have not decided to endorse or cosponsor the particular piece of legislation that is trying to address this problem because I want to make sure that we don't undo what we have really wanted to do here for a long time, and that is get tough on waste, fraud and abuse. But we need to know more about that.

Miss DeParle?

Ms. DEPARLE. Yes, sir. I can't speak for the Justice Department or the Inspector General either, but I can tell you what my goal is, and that is to make sure Medicare gets what it pays for. And I think that is the thing that you and others in this committee and the other committees have also spoken to.

If I could just make a comment about how the user fees relate to that. I understand and appreciate all your concerns, and I know that you are frustrated by this, as well as I am. The problem is

that I think what this audit demonstrates is the only way to do a better job of making sure that Medicare gets what it pays for, or the best way, is that you have to have time to look behind the claims, because the claims that are coming in look okay. And to do that we need to spend more on audits and medical reviews. And you know that our budget right now is very small in relationship to the amount of claims and the amount of dollars that come through.

My recommendation to the Congress is that we need to have more funding to spend on doing these audits and medical reviews. That is the only way we will be able to address this problem. That is why we are seeking the user fees. And as I said, I understand and appreciate your concerns about them, but I want to make clear that they do, I think, relate to a commitment that we both share.

Mr. BILIRAKIS. Well, I think we have provided \$400 million toward this overall effort.

Ms. DEPARLE. You did, and that Health Insurance Portability and Accountability Act, which went through your committee, has made some important contributions to the effort, I think.

Mr. BILIRAKIS. Do you think that the Justice Department is being overzealous?

Ms. DEPARLE. Well, I don't think it's really appropriate for me to comment on their prosecutions. I am not familiar with exactly what they have done. I can tell you from my perspective I want to be sure we set tough and clear rules for providers and then expect them to live by them. It is the Justice Department's role to then enforce them.

Mr. BILIRAKIS. I have endorsed that statement. I have said that more than once. And, again, I don't know about Mr. Barton's opinion on the way the False Claims Act is being used by the Justice Department, but I know how tough he is on waste, fraud and abuse. But I am here to say to you that what we must be clear in terms of what the rules should be for these providers and then hit them hard if they don't abide by those rules. But that is not the sort of picture I am getting from people out there.

Thank you very much. Thank you, Mr. Chairman, you have been more than fair.

Mr. BARTON. Thank you, Congressman.

Before I introduce Mr. Kucinich for really his first round of questioning—on the False Claims Act, I am not a cosponsor of the McCollum bill. I think that goes way too far. I do think the Justice Department, in some instances, has been overzealous in the way they have used the False Claims Act, and I have got a number of options under consideration, and, quite frankly, I want to talk to you about those privately.

Mr. BILIRAKIS. We will have to do that, Joe. Thank you.

Mr. BARTON. Mr. Kucinich.

Mr. KUCINICH. Thank you very much, Mr. Chairman.

Picking up from what Mr. Bilirakis was asking of Ms. DeParle, is it true there is about 4,700 hospitals across the country that have received demand letters, referred from your department to the Department of Justice, claiming each has fraudulently billed the government?

Ms. DEPARLE. Sir, those demand letters would be from the Department of Justice. I don't know the number of them.

Mr. KUCINICH. You make the referrals, don't you? Don't you inform them?

Ms. DEPARLE. We don't make those referrals. This is, I believe—

Mr. KUCINICH. What is the connection, then, between your department and the Department of Justice when it comes to determining whether or not billing has been fraudulent or not?

Ms. BROWN. Mr. Kucinich, if I could give you an example, our 72-hour window project. We did four audits over a period of years and found that people were getting treatments within 72 hours of the time they were admitted to the hospital, something like a test that would have to do with their admission to the hospital. And if it is within 72 hours of their admission, those tests are included in the overall cost of that hospitalization. But they were being billed separately.

We found some hospitals, even after being audited several times, were still carrying on this practice. So the penalties, which we worked out very carefully with the Department of Justice, and we worked with the hospital associations, too, were based in part on the number of times they had been audited. We warned that this was something that had to be paid back and was inappropriate.

Mr. KUCINICH. Where does that come on the chart there?

Ms. BROWN. That is not part of this at all. This is a separate audit. It isn't part of this financial statement audit.

Mr. KUCINICH. So what I'm trying to find out, though, is how is it that hospitals are notified that they have fraudulently billed the government?

Ms. BROWN. They are notified in various ways, but it could be by letter.

Mr. KUCINICH. Where does it start, though? Where does the process start? I want to have an understanding of this process. Where does the process start?

Ms. BROWN. Well, I have to use one audit as an example, because they are all different. In the 72-hour window project, we would start by going in and examining whether billings were within 72 hours of the admission for the tests that were required as part of their admission.

When we discovered that these were being billed over and over again, the same way, even though the hospital had been previously audited and knew that was not proper and had to repay in the past, if they continued that, we came up with a penalty based on the number of times they had been warned. So those who had been found to have committed this offense in all four audits over a period of about 6 or 7 years had to pay a much greater penalty. Those who only were found to have done it for the first time would just have to repay the dollar amount and interest.

Mr. KUCINICH. Now, where fines are threatened, is that usually in the case where somebody has been warned a number of times, or is that for the first infraction?

Ms. BROWN. It is usually when they have been warned a number of times, or when there is documentation which proved that they had an intent to defraud.

Mr. KUCINICH. Do you have any idea how much of the \$20 billion, that number that has been thrown around in overpayments, is fraud and how much of it is incomplete paperwork?

Ms. BROWN. No, there is no way I could determine that.

Mr. KUCINICH. Has anybody tried to determine it?

Ms. BROWN. No. This has just been completed, and we know that there was some reason that that bill came in—

Mr. KUCINICH. Here is where I have a problem. If we haven't really tried to make that determination, then hospitals are receiving letters which, in effect, accuse them of fraud.

Ms. BROWN. There are no letters in connection with this audit at this time. Now, the previous year there was ample opportunity for them to make a determination or justify why this service was performed when it shouldn't have been. If they can provide that evidence why—

Mr. KUCINICH. Let me give you an example. Mr. Chairman, you might find this instructive. Again, this isn't taken as criticism, I want to illuminate a problem here which I think I have found in the 10th Congressional District.

We have Parma Community General Hospital. It is an independent hospital. It has a reputation of serving the community honestly and ethically. And they received a letter in 1996 which basically threatened huge fines if they didn't voluntarily settle. And the subsequent findings of an audit over a 6-year period found an error rate of only 0.6 percent.

By exercising its legal rights, instead of voluntarily settling, they could have been exposed to an adverse finding of nearly \$100 million under the False Claims Act. You know, this I consider to be a serious matter, because how many hospitals are out there getting slammed with demands for payment or accusations, when the truth is they may not actually be doing anything that is wrong, and they might have a very low error rate?

How do you explain that?

Ms. BROWN. Well, in order to use the False Claims Act, we have to show that there was deliberate disregard of the law. I don't know what happened in the case of the Parma hospital. I would be glad to see if that is a case that we had participated in and get some answers.

Mr. KUCINICH. Here is what I am concerned about. I am sure you can appreciate this concern. It seems we are paying for-profit intermediaries, insurance companies to process claims, which they effectively rubber stamp, and then turn around and audit hospitals annually for payments they have, in fact, approved and been reimbursed for. Yet HCFA and the Department of Justice are using the False Claims Act to force hospitals into making payments when they have been given virtually no choice but to pony up.

I just wonder how particularly helpful this is to the Medicare program.

Ms. BROWN. Well, again, each one of those cases is separate. I would be glad to have my staff work with yours or get some answers for you on the particular case you are speaking of.

Mr. BARTON. Will the gentleman yield?

Mr. KUCINICH. Gladly yield to the Chair.

Mr. BARTON. Is it possible to create some sort of escrow account so that the intermediary is at risk if, in fact, the claim later proves that it should not have been paid?

I think the gentleman has got an excellent point. Is it fair to the hospital if the intermediary pays the claim? Shouldn't the intermediary bear some responsibility if at a later date, because they go into a background check, that, in fact, that claim perhaps should not have been paid?

Could we create a contingency account or an escrow account so that a certain percent was held back or that the intermediary would be liable?

Ms. BROWN. I don't know off the top of my head whether that could be done, but remember that what was submitted was not representative of what was actually shown in the medical records. So it is like a tax return. Somebody could submit something that seemed to be totally legitimate and would go through the auditing at IRS, but they, in fact, didn't have the deductions that they claimed they had.

Mr. BARTON. But to use your example, if I take all my records to my CPA and say, do my taxes, the CPA has to sign as a professional CPA, and then it goes in the IRS. So if the IRS kicks it back, my CPA is liable.

Ms. BROWN. Under certain circumstances, being a CPA, I could say, yes, that is true.

Mr. BARTON. I sign my mother's tax returns. I did hers, and I signed hers, and I guess I'm liable if I screwed up.

Ms. BROWN. Well, if the CPA had falsified records from you, then the CPA wouldn't be liable. It would be the person who gave him those falsified records, and that is what we are talking about.

We are saying there isn't a record. The medical file on this individual either didn't show they had that service, or they weren't eligible for it, or it was an ineligible service and they charged for something different.

Mr. BARTON. There are some proposals that are before the Congress to allow HCFA to theoretically do some sort of competitive bidding for intermediary services. So there are some ways we can begin to address some of these problems, but I think the gentleman has an excellent point; that it is a little unfair to purely attack the hospitals if somebody else has said it is okay.

Mr. KUCINICH. I will conclude this where I started off, by pointing out that Mr. Bilirakis has certainly raised what I think is an important issue under False Claims, and I cited a local community hospital that is a wonderful hospital that was basically hammered. And when they stood up for their rights, they found out it was a very low error rate.

I have further been informed by staff, which went over to the Department of Justice and began to review some of these cases, that we have many hospitals that are being conscientious, and yet the Department of Justice is really being extraordinarily aggressive. Would they be so aggressive on antitrust matters—hello!—but they are not.

I think it is important, Mr. Chairman, at some point, for us to get the Department of Justice to explain how they get to this point; what the methodology is for them to be so aggressive with hos-

pitals. And also it would be interesting to see what exactly the error rate is at the hospitals, because it is my understanding that thousands, and Mr. Bilirakis, you probably know this, since you raised the issue, thousands of letters are being sent out.

Now, that doesn't mean that HCFA isn't doing its job. I understand you are doing your job. And we are all concerned about fraud and abuse. Every one of us on this committee, everyone in the Congress is concerned about that. But we do not want local hospitals being attacked under color of laws dealing with fraud and abuse and scaring local hospitals to the point where they are ready to fork over millions of dollars because they are afraid of basically being debarred from this kind of work.

Thank you, Mr. Chairman.

Mr. BARTON. The gentleman's time has expired.

I would simply say that the False Claims Act was passed in 1863, during the Civil War, when President Lincoln was pulling his hair out with all the government contractors providing insufficient equipment and supplies for the Union cause. It was revitalized during the Reagan Administration and used extensively in defense contracting and saved billions and billions of dollars.

So the answer is not to repeal the False Claims Act or to gut it. The answer is to find out what the underlying problem is and work with the Justice Department and the health care community so that it is only used when it is appropriate.

Before I ask my questions, does the gentleman from Florida wish to make a statement on this?

Mr. BILIRAKIS. Well, Mr. Chairman, yes. I think there is what I interpret as a real concern on all of our parts regarding this immediate subject that we are talking about. I would like to propose, with your able leadership, that we maybe set up a gathering. It doesn't have to be a hearing, but a meeting with the Justice Department, possibly maybe with some of their records.

Mr. BARTON. Well, I have a pending request from Congressman Klink, the ranking minority member of the Oversight and Investigations Subcommittee, to do something similar to that.

Mr. BILIRAKIS. We have to be careful because we don't want to undo all of the good that we have done in terms of the waste, fraud and abuse situation. So it is a very sensitive area, there is no question about that, but there is great concern on our part.

Thank you very much, Mr. Chairman.

Mr. BARTON. Just a second.

I am just talking about flight arrangements here. This hearing has gone a little more expeditiously, so I am being encouraged to take a 12:15 flight, but I don't think I'm going to be able to do that.

The Chair is going to recognize himself for 10 minutes and try to refocus the hearing away from the False Claims Act, which is an important issue in and of itself. Is there anybody in the room who is for waste, fraud and abuse? Anybody who thinks it is acceptable? No?

We are all agreed that we are against this problem. The Congress could pass a law saying, you shall not pay for waste, fraud and abuse. Would that solve the problem if we just passed a law and said you can't pay for it? That wouldn't solve the problem. So we have to work together on this. This is a bipartisan issue. Repub-

licans are against it, Democrats are against it, health care provider community is against it.

When I talk to my hospitals and doctors and physicians and home health care people, they are not for waste, fraud and abuse. They want to be compensated fairly and, as Ms. DeParle pointed out, on time. So we really need to focus on what the real problems are.

I noticed in the Inspector General's testimony that you have been working with HCFA, and that HCFA has agreed to cut their error rate to 10 percent by the year 2002. That is not acceptable. I mean, it was 14 percent, plus or minus, last year, and it is 11 percent, plus or minus, this year.

What would you all think if I said my error rate in my congressional election is plus or minus 10 percent of the vote? We have 200,000 people voting, so plus or minus 10 percent is 20,000 votes. So if I don't beat my opponent by more than 10 percent, he can, or she can, claim a recount because it is within the error rate. You only won by 19,000 votes, Congressman.

Mr. KUCINICH. Mr. Chairman, if you used that approach, I think we would be running the Congress.

Mr. BARTON. Well, that may be good, I am not sure. There are days, I think, Mr. Bilirakis and Mr. Horn and I would let you run the Congress, but not today, by the way.

So my first question, and this would also, I guess, go to Secretary Shalala, who is not with us, shouldn't we come up with a plan that, if it is successful, would get the error rate down to like 2 percent, 1 percent?

I mean, Visa and American Express, I have talked to them, their acceptable error rate is a half of 1 percent. So why should we have an error rate for Medicare that is 10 percent?

Ms. DEPARLE. I knew you were going to ask me that question. I have thought about it.

Mr. BARTON. Great minds think alike.

Ms. DEPARLE. The 10 percent goal was something that was stated last year at the first audit.

Mr. BARTON. And I complained about it last year.

Ms. DEPARLE. You did, and I wasn't here then, but I have heard about your comments, and you and I have talked about this.

To be honest with you, I thought it would be much worse this year. We added durable medical equipment claims to the set of claims that the Inspector General analyzed, and, based on what I knew about that, the problem with that provider community, and actually if you look at page 9 in their report, you will see what I mean, there are problems there. I expected it to be worse.

I don't think 10 percent is a good enough goal now, especially not with the progress we are making. I don't know that I want to set a number sitting here. I need to talk to Secretary Shalala about it as well. But I can tell you I am committed to making progress every year, and we need to work together to do that.

Mr. BARTON. Well, we can set a number in law. We can't meet it, but we can give you a mandate, and I think we will have bipartisan support on that. We don't want to be unrealistic, but you have a better chance of hitting something if you aim at it.

Ms. DEPARLE. I understand.

Mr. BARTON. And if you aim at 10 percent, you will probably make 10 percent, because you are in that ballpark now. But 10 percent in the year 2002 is probably going to be over \$20 billion because the program is growing.

Ms. DEPARLE. Right.

If I can say another word, too, Mr. Chairman, about the folks at Visa and MasterCard and those places. I have met with them, too, and the key difference that I see between the way they run their business and the way we run the Medicare business is they have much tighter control over their network. You don't get into Visa as a bank or as an institution without being thoroughly checked out, without being responsible and accountable for whatever happens. They have a very tight network. Well, we need to do some more—

Mr. BARTON. Why can't we do the same thing?

Ms. DEPARLE. We are doing some things like that, and some of them are hard, but we are doing them.

Mr. BARTON. I know that. But we start these programs and let them grow topsy-turvy. Home health care is an excellent example of that; a good idea, good intentions, but not a lot of requirements to get into the business. Now we are trying to reverse it.

But I would think you would want to be more strict on who provides health care and is paid by Medicare than you would on who is eligible to be reimbursed by Visa for buying gasoline.

Ms. DEPARLE. You and I don't disagree about that, but as you know, when the program was set up, there was a concern there wouldn't be enough providers. Chairman Horn talked about the concern that there be home health, because it wasn't really out there. So there weren't very many requirements, and now we are trying to put some of those in to deal with this problem.

Mr. BARTON. Let's talk about some solutions. In last year's Balanced Budget Act, myself in the House and Senator Graham in the Senate were able to get in some requirements for a competitive bidding test program for durable medical equipment, and we have given the Secretary of Health and Human Services approximately a year to set it up. And I think there is going to be test programs in six regions of the country for a 2- to 3-year period.

I don't know if Ms. Brown would be the one or you would be the one. Can you give us an update on what Secretary Shalala is doing to implement this competitive bidding test program pilot project?

Ms. DEPARLE. I sure can. There are two of them, two major components of it: One is in the durable medical equipment area, and we are almost ready to go forward with that. I think it will be in the next few weeks. What we are doing right now is preparing the letters and the kinds of contacts that we are going to need to make with the beneficiary community in the areas where we do the demonstration, because, obviously, we don't want them to be worried about how it is going to affect them.

The other major area of competitive bidding is in the purchase of HMO services, and this was something that HCFA had tried to go forward with but it didn't work out. However with the Congress' support I think we will be able to do something there.

In the Balanced Budget Act you set up an advisory committee that operates almost like a base closure commission, I guess, and

they are going to help pick the places around the country. I believe their first meeting is next week to begin picking the places. And then in each of the areas that are selected, there will be a local group of people who will work on moving that forward, because it is so hard to make these kinds of changes in the Medicare program without the community's support.

So I am hoping that will be going forward by the end of the year as well.

Mr. BARTON. You mention in your testimony that you have requested additional authority to go out and do basically a competition for who is going to be the intermediary. Do you want to elaborate on that?

Ms. DEPARLE. Yes, I would like to. I think for the past 4 years we have sought legislation to allow us to change the way we do business with contractors. The original Medicare law said we had to use certain types of companies, insurance companies, to pay the claims. And that was set up that way because of the dynamic, I guess, at the time of how Medicare could be passed. We think now that it would be a good idea to have more competition in this claims payment area.

In the payment safeguard or program integrity area, you gave us that authority a couple of years ago in the Health Insurance Portability and Accountability Act, and we have just put out a regulation in March to start doing some competitive bidding there to get some new kinds of program integrity contractors in, because there are other folks in addition to insurance companies who could do this kind of work, and we would like to make it competitive and create some incentives for better performance.

Mr. BARTON. Under the current law, is it legally possible to give your intermediaries a bonus if they have fewer bad claims, if we created some incentives to do it right the first time? I mean all the way down the line, including maybe the physicians and the hospitals.

Do you have that authority now—not you personally, but the executive branch—or would that have to take an act of Congress?

Ms. DEPARLE. On the claims processing side, our contracts are not the typical FAR contracts. They are special contracts under Medicare, and we pay them on a cost basis only to process the claims. I don't believe we have the authority to give them incentive payments, and certainly an important point to Mr. Kucinich's question is that we are required to pay these claims, clean claims, which as the Inspector General said, 98 percent of the claims that came in were clean. We have to pay those within 2 weeks, basically.

So there isn't any incentive. These claims just go through the door. And that is why I have asked for more funding to do audits and medical reviews, because that is the only thing that gets behind the claims, looks at them, and then we know where these errors are. Otherwise, the money just goes out the door, as you all have seen.

Mr. BARTON. My time has expired. I will recognize Mr. Horn for this second round, but, before I do, one final question.

I am one of the proponents of medical savings accounts for senior citizens. I think if you put the money in their name and reestablish

a direct relationship between the health care provider and the patient, where the patient has got control over the funding, that it might go a long way to eliminating some of the complexities and some of the problems that Inspector Brown has uncovered.

Do you have a comment on that?

Ms. DEPARLE. As you know, we are doing a demonstration on that. That will be starting later this year. That was part of the Balanced Budget Act.

I guess you and I have discussed this. I do think medical savings accounts pose some other potential problems, but we are going to see how it goes. And I think you have made a good suggestion that we look at the beneficiaries' experience in terms of claims error rates, if you will. Perhaps if they will be getting the statements themselves, and they will be paying them themselves, maybe they will have a greater incentive to make sure they are accurate.

Mr. BARTON. Well, there is kind of a law of diminishing returns. If you determine the only way to correct this problem is through more regulation, as Congressman Norwood was pointing out, you get to a point where the regulations themselves become so incomprehensible or complicated that even honest people can't comply with them. So the way to cut that knot is to do away with the regulatory model and go to a competitive model and then allow the marketplace, i.e., the provider and the recipient, to negotiate for themselves. It is just a different thought, different theory.

Mr. Horn for 10 minutes.

Mr. HORN. Thank you very much.

First, I would just like for the record, what is the policy as to what you pay the insurance provider, or rather the insurance intermediary between the provider and Medicare? How do we reimburse them and pay for their services?

Ms. DEPARLE. As I said, these are special contracts, Mr. Chairman, that are not in the regular government contracting authority. It is Title 18, and they can be paid on a cost basis only, not like the other contracts. And what that means is we have often less ability to do anything about it if they are not meeting the requirements.

For example, one area I know you are interested in is in the millennium, or Y2K. When I got there, one of the things I wanted to do was to put an addendum to our contracts to require them to be millennium-compliant by December 1998. My staff drafted something, but the contractors were all refusing to sign it. And under Title 18 they argued, you pay us to pay claims on a cost basis. There is no basis for any kind of addition like that.

Mr. HORN. Give me an example. Let's say they clear 200,000 claims in a quarter. What are they getting for that, a dollar a claim? Or is it a percent of the claims or what? How do you reimburse them?

Ms. DEPARLE. I think it does amount to somewhere around a dollar a claim, but I am not positive, and I will get back to you for the record.

Mr. HORN. Do that for the record. I am curious.

[The following was received for the record:]

Contractors who process hospital and most other Part A claims are paid on a cost reimbursement basis for claims processing, as well as beneficiary and provider serv-

ices. Annual budgets are negotiated, based in part on the number of claims that the contractor is projected to process over the course of the year. For budgeting purposes, we estimated the average cost to process an individual Part A Claim for Fiscal Year 1998 to be \$1.07.

Mr. HORN. Is there an incentive, for example, for them to clear a number of claims without looking at them too carefully because that is how they are paid?

Ms. DEPARLE. I think, sir, there probably is, and I think also Medicare is the largest processor of electronic claims. We have moved heavily in that direction. That is good for the purposes of efficiency, but for the purpose of taking time to actually look at claims and go behind them and see whether they are right, it might impose other incentives.

Mr. HORN. Yes, because I would think we would need to deal with that in some way. If it is strictly competitive bid, is it that you put these out, or how does this work? Or do they—once you hire them, do they stay with you for all eternity or what?

Ms. DEPARLE. No, the contractors, under law, on the Part A side, the providers get to designate who is going to be the fiscal intermediary, and it is usually Blue Cross and Blue Shield they have chosen around the country. And on the Part B side there are a bunch of different contractors.

I wouldn't say it is a competitive bid, because they are also required to be insurance companies, and most of them have been in place for a long time. I should say many of them do a good job. We need to work together with them and with the Congress to look at how to make this situation better.

Mr. HORN. Let me move to the next question, which is, I think, a policy under review. As I understand it, under the Balanced Budget Act, HCFA was required to propose a rule for the Medicare physicians' fee schedule. This proposal was initially to be implemented on January 1, 1998; however, because of difficulties in developing the proposed fee schedule, implementation was delayed until January 1, 1999, that is my understanding. And I believe you are now supposed to be publishing a new proposal on this on May 1, 1998, next week. Is the proposal going to be issued on May 1?

Ms. DEPARLE. I don't believe it is. My staff are still hopeful that they will make the deadline, but it is still being reviewed by a number of people. And I think what you are referring to is the new practice expense component.

Mr. HORN. That is correct. And I want to hear your understanding of the methodology being pursued to separate direct and indirect cost of the practice expense. Are we just lumping it in on an average nationwide? Are we going to look at it specialty by specialty?

Ms. DEPARLE. We are trying to look at it specialty by specialty. The Congress directed us in the Balanced Budget Act to go back and look at our methodology again, and the GAO has also looked at this. We have met countless times, with a number of the specialty societies. I myself have met with a number of them, and we have a new proposal that we are going to be putting forth.

I think we will be a week or so late. As I said, my staff are still hopeful we will make the deadline, but, as you say, it is next Friday, so I am not confident we will make it.

Mr. HORN. If you are doing it specialty by specialty, which I think is the only way to do it, personally, are you just taking a random sample of particular specialties and their billing experience and their cost? Obviously, there are regional differentials here, we all recognize. And I would appreciate the Inspector General's thoughts on this also.

Ms. DEPARLE. Well, what we are considering are some data that we have received from the American Medical Association, and we are also considering other data we have received from specialty societies. So that is how we are looking at it.

Mr. HORN. How about it, Inspector General?

Ms. BROWN. I have not looked at this area, so I would rather not comment.

Mr. HORN. Well, I think you should look at the area, frankly. I think it is a very important one because there is going to be billions of dollars here at stake on how those costs are figured. So I don't know if anybody in your shop has followed some of the predecessor approaches here, but, obviously, I think it makes sense to do what you are doing, if you are doing it specialty by specialty.

But then the question is how are you arriving at those particular numbers? Are these simply a random sample, or are you depending upon the professional societies, as you mentioned them?

Ms. DEPARLE. What I want to do, Mr. Chairman, is get the doctors who have worked on this to do a briefing for you.

Mr. HORN. Good, I would appreciate that.

Mr. Chairman, in light of your desire to return to that great State, the State of Texas, I will file a number of questions with you, if you don't mind, and we will put them in the record at this point.

[The questions and responses appear at the end of the hearing.]

Mr. BARTON. We assume you may want to go to the great State of California.

Mr. HORN. No, this is the weekend I am not. I have been there 5 weekends in the last 5 weeks.

Mr. BARTON. Too much of a good thing is just too much.

Mr. HORN. That's right.

Mr. BARTON. Mr. Kucinich, the gentleman from the great State of Ohio.

Mr. KUCINICH. Thanks, Mr. Chairman. I want to cover a few things here very quickly that I started at the beginning of the hearing, and I would just like to continue.

Today, the Inspector General announced that we have a \$20.3 billion problem in the Medicare program, and my question is exactly why isn't the private contractor that we are paying to safeguard this program doing the same kind of audit which the Inspector General just did to discover these problems, because if we are saying that \$20.3 billion worth of losses is not acceptable, then aren't we really saying the way the private contractors are overseeing the Medicare program is not acceptable? And if the private contractors are so expeditiously processing and paying claims, really rubber-stamping the claims, then why do we have them?

The government itself could just rubber-stamp the claims and throw them out within 2 weeks. What is the point of this? Enlighten me.

Ms. BROWN. Well, it is a difficult problem because the look-behind, the type that we did, is quite expensive to do. I think one of you brought up 2 percent earlier, and this type of review is only done in very few of the cases by the contractor. As Ms. DeParle mentioned, they are stepping up the number of reviews that they are doing.

Mr. KUCINICH. I will bet they are. I would like to know, you know, this is my first term in this Congress, and I am kind of interested in what these private contractors do. Have you, Inspector General, ever done a very deep and detailed analysis of the role of private contractors and all the wonderful things they are doing?

Ms. BROWN. We have done many studies of the private contractors, and in one case, for instance, we found that they lied and had turned off the edits in order to get—

Mr. KUCINICH. They lied, is that when you said?

Ms. BROWN. They lied, and turned off edits in order to get all of the claims processed much faster, and that contractor was forced out of the program. So, you know, there are many ways contractors can be either very reliable or unreliable, and we have a regular series of things going on, either—

Mr. KUCINICH. Well, Ms. DeParle, why isn't the government more involved in this instead of less as far as doing the work the private contractors are doing?

Ms. DEPARLE. We are getting more involved in it. What we need to do is increase the number of audits we are doing and the number of medical reviews and the kinds of focused reviews you are talking about, and we are seeking the funding to do that. What we have the money to do right now is process and pay claims. You are right, that is not the problem. The problem is in the error rate.

Mr. KUCINICH. Thank you.

I want to introduce for the record an article that was in the National Journal of Congress Daily on Thursday, April 23, 1998, and in the article they—I just was passed a note from staff, excuse me, you know how that happens, Mr. Chairman. The note was, increase the audits, why not just get rid of the private contractors? Actually, I am all for that. Now, you know, just make a footnote of that.

I want to introduce this matter, this article that was in the Congressional Daily, Congress Daily, and it is about the Health Care Financing Administration. It is not particularly flattering to the Congress, but what it does do is it points out the tremendous increase in responsibilities which the Health Care Financing Administration has, and makes a case for the fact that you really do need some additional resources in order to discharge your responsibilities that you have been able to take upon you. I want to thank you today. Thanks to the Chair and Mr. Horn for this hearing. Thanks.

Mr. BARTON. We will introduce this for the record, without objection. Is there objection to this being put into the record? Hearing no objection, so ordered.

[The information referred to follows:]

HealthMATTERS

Congress v. HCFA: Bureaucracy Bashing 101

By Julie Rovner

■ **FRUSTRATED POLITICIANS LIKE TO POINT OUT** how hard it can be to please constituents who simultaneously demand contradictory things — like those voters who all at once want increased spending, tax cuts, and no new additions to the deficit. But sometimes, the politicians themselves behave just as inconsistently.

Take the Health Care Financing Administration, known — and almost universally derided — as HCFA (pronounced Hickfa). The HHS subunit that oversees Medicare, Medicaid, and, since last year, the new children's health insurance program, HCFA is the agency politicians most love to hate. In 1992, when he was running for president, candidate Clinton in his "Putting People First" manifesto vowed to "scrap [HCFA] and replace it with a health standards board made up of consumers, providers, business, labor and government."

In short, anybody except bureaucrats.

During the heated Medicare debate of 1995, **Speaker Gingrich** claimed he never meant to suggest Medicare would "with'er on the vine" under the GOP's budget plan, merely HCFA.

But Congress' second favorite pastime, after beating up on HCFA, seems to be giving the agency even more work to do. Since 1996, three different bills have increased HCFA's responsibilities exponentially.

"It's the greatest workload in the history of the agency," said Harvard Professor Joseph Newhouse, vice chairman of the Medicare Payment Advisory Commission.

And it is not like HCFA was a sleepy bureaucratic backwater: Running Medicare and Medicaid already required it to supervise the healthcare programs that will serve nearly 75 million Americans in 1998 and cost the federal government \$300 billion in 1997, 18 percent of the entire federal budget.

■ **HCFA'S LATEST ONSLAUGHT** began in 1996, with passage of the Health Insurance Portability and Accountability Act. Not only did HIPAA give the agency broad new responsibility to root out fraud and abuse in Medicare (the accountability part), it also made HCFA the fallback enforcement agency for states that failed to pass their own laws to implement the portability part. As of now, that includes five states: Rhode Island, Massachusetts, Missouri, Michigan, and California.

Later that fall, Congress ordered HCFA to implement provisions tacked onto the VA-HUD appropriations bill barring "drive through" baby deliveries and requiring limited parity for mental health coverage.

But that was only an appetizer. Last year's Balanced

Budget Act, according to HCFA Administrator Nancy-Ann Min DeParle, gave the agency about 300 new tasks.

In Medicare alone, the agency is expected to devise new payment systems for home health, hospital outpatient, and nursing home care; a new "risk adjuster" and new payment methodologies for managed care plans; and rules for new "provider-sponsored organizations." And that is not to mention devising how to inform Medicare's 39 million beneficiaries about a vast array of new "choices" available to them this fall.

At the same time, HCFA is responsible for approving each state's new children's health insurance program, and for helping states locate and enroll the millions of children eligible but not yet signed up for Medicaid.

With that much more to do, you might think Congress would also give HCFA more money to do it with. But it is so easy to bash the bureaucracy that the Senate could not resist striking HCFA's request for an additional \$16 million for FY98 during consideration of the supplemental appropriations bill last month.

HCFA officials said \$6 million of that request was to hire workers to enforce HIPAA in states that have yet to pass their own legislation. The states in question contain a total of 54 million citizens. "The work requires knowledge and expertise in the area of health insurance regulation at the state level," said the agency in its supplemental request. "The nature of this work is totally unlike that performed by HCFA's workforce."

But that plea fell on deaf ears. "Do we want to turn that much additional bureaucracy over to HCFA, that much more money, or can't they borrow some more of those employees that they now have who are probably reading through reports that are obsolete and maybe not doing so much good?" asked **Senate Majority Whip Nickles** on the floor March 25.

Evidently they can, according to the Senate. Members adopted Nickles' amendment to strip the funding from the bill after defeating, 51-49, an attempt by **Senate Labor and Human Resources ranking member Edward Kennedy**, D-Mass., to keep only half the money.

The result of all this, says former CBO Director Reichbauer, is "setting HCFA up" for failure. "It's classic Congress," he said. "There's no way HCFA can accomplish the changes Congress has asked [it] to do. Then [Congress] will be back in two years having oversight hearings about how HCFA failed to do its job."

Mark your calendars now.

— **HEALTHMATTERS CAN BE CONTACTED BY E-MAIL AT: JROVNER@NJC.COM**

Mr. HORN. Mr. Chairman, if I might, I would just like to put in the record here the staff who have worked on this for the Subcommittee on Government Management. They are: J. Russell George, staff director and chief counsel; Dianne Guensberg, the GAO detailee we have working on audits; John Hynes, professional staff member; Matthew Ebert, clerk; Mason Alinger, staff assistant; Kami White, intern; Faith Weiss, counsel for the minority; Lisa Chamberlain, also L.A. to Mr. Kucinich; Earley Green, staff assistant for the minority; and our court reporters, Pam Garland and Julie Bryan. Thank you very much.

Mr. BARTON. Without objection.

The Chair is going to recognize himself for the last 10 minutes of questions, and I don't think it will take 10 minutes.

Ms. Brown, this is the second year that your department has done this audit. Do you think that HCFA is moving in the right direction or the wrong direction?

Ms. BROWN. I believe they are working in the right direction. Just as we have already started the 1998 audit, by the time this one was started and they got the results of the 1996 audit, most of the year had passed, so it is going to take at least a second year and sometimes even longer to see the results of the program that they have embarked on to correct errors.

Mr. BARTON. Do you think they are making a good faith effort and they are working with your staff?

Ms. BROWN. Yes. We meet with them regularly and go over the things that can be done and their suggestions as they review all of those with us, so I think we are working together in a very productive way.

Mr. BARTON. I noticed that last year—not you personally, but the report made a number of specific recommendations, and this year you basically say that you have no additional recommendations that you wish to make. Of the recommendations that you made last year that have not yet been fully implemented, which ones do you think are most important that HCFA focus on this year?

Ms. BROWN. Well, they are focusing on all of them; it is just that I believe that they have not had time to see the results, because they got those recommendations in the last quarter of the year we just audited, and so they are at some stage of implementation on all of those recommendations.

Mr. BARTON. There is not one particular action item that is more important than the others that we would or that you would want this subcommittee or subcommittees to focus their attention on that would help solve these problems?

Mr. VENGRIN. Yes, Mr. Chairman. I would like to clarify. From my perspective, I don't necessarily see the contractors really doing a poor job. I would like to, again, for the record say, based on these claims that we examined this year, on the surface these claims appeared correct. It was not until we went back and obtained the medical evidence that problems were found. In some cases, Mr. Chairman, the physicians were not wearing out a ballpoint pen in preparing medical documentation. In some cases I have before me one sentence to support of the services rendered. That is clearly contrary to guidance AMA developed in coordination with HCFA.

So in answer to the question, more postpayment review is needed. The problems that were identified by this audit were detected this way. So that was the strongest action I could recommend.

Mr. BARTON. Okay. We have danced around this question, and I have to ask it for the record, both Ms. DeParle and Ms. Brown. In your opening statements, you point out an error rate, and then you say it could be plus or minus so much percent. You talked about wanting to work on waste, fraud and abuse, and then you say, we don't necessarily say that all of these problems are attributed to fraud and abuse, but are due to insufficient documentation, lack of medical necessity.

What is your educated opinion as to the percent of fraud?

Ms. BROWN. Lack of documentation can indicate fraud. For example, we went out at least three times and even made personal site visits in order to get documentation. So it isn't a matter of the documentation not just being put back in the file or something like that. These are things where there is no record of a service being performed. And so those aren't as vague as they might appear up there.

I can't come up with a number, but I think that a reasonably large proportion of those are due to some type of fraud and abuse.

I might also, if I may, just mention that these are only the fee-for-service claims, and the percentage of the fee-for-service. There are other types of fraud as well. So if somebody is creating documentation in a fraudulent manner, if they are—

Mr. BARTON. Well, what about the lack of medical necessity? Does that lend itself to a fraudulent interpretation?

Ms. BROWN. It could, because if somebody goes to their doctor and wants something done that may be cosmetic in nature or some other thing that isn't covered by Medicare, and the record doesn't show that there is a necessity for the type of service being performed, then it could be fraud. On the other hand, it could be some other interpretation.

Mr. BARTON. Well, if you took no documentation, no documentation due to investigation and lack of medical necessity, that is over 50 percent, so that would be over \$10 billion is fraudulent. Would I be irrational if I said half of the error rate that you found is probably because of fraud?

Ms. BROWN. I couldn't contest that figure.

Mr. BARTON. You would not contest it?

Ms. BROWN. I could not contest that figure.

Mr. BARTON. What about you, Ms. DeParle? What is your best guess as to what percentage of this is fraud?

Ms. DEPARLE. Well, I think maybe I would say you were a little bit high, just in thinking about it. I think the category that troubles me the most is the one that Ms. Brown just highlighted, no documentation due to investigation. If you look at that chart on page 9 of her report, the claims in the durable medical equipment area, more than half of the dollar amount of the claims they looked at is in that category of documentation not provided due to extenuating circumstances. What that means is there is a review going on, perhaps an investigation going on, and I think those are the categories that I am most concerned about that could be actual fraud.

Mr. BARTON. Okay. Well, you know, we can't put a number on it specifically, but we can get in the ballpark, and the problem that those of us that are elected have, we hear the other side a lot more. The doctors talk to us, the hospitals, the hospital boards, the home health care providers, and their story is that they are just overwhelmed with paperwork and bureaucracy and complexity, and so we have to balance all of this out. And as I have told you, and Congressman Bilirakis alluded to this, I want to throw the book at the bad guys, but I got a lot of people that I don't think are bad guys who are going out of business right now.

Mr. KUCINICH. Would the gentleman yield?

Mr. BARTON. Sure.

Mr. KUCINICH. The chairman is absolutely right. My question is where is the fraud here? You know, fraud involves intent, and I don't know in this report, have you covered that?

Ms. DEPARLE. There are some examples in here of things that I think you would categorize as that, where there is no provider there at all who has been billing us, that I view as fraud.

Mr. BARTON. I agree with Ms. Brown. I think HCFA is moving in the right direction. I think there is an honest effort. I think you give the Congress a lot of credit, and I think if you want to be a little bit more partisan on this, I think you should give the Republican leadership some credit in Congress for focusing attention on this.

Medicare/health care waste, fraud and abuse 3 or 4 years ago was a very low priority. You know, if you wanted to talk about fraud, you looked at the Defense Department, you looked in the narcotics area, you didn't really focus on health care. And to our credit we have done that with a lot of support from the Democratic side on this committee and, I would assume, on Congressman Horn's committee. But we need to come up with ways to differentiate between honest mistakes and intent. I can't make those decisions, but I am hopeful that what we are doing in our dialogs helps that, and I certainly want to commend the Inspector General for your efforts to put some methodology to this.

Ms. BROWN. Thank you.

Mr. BARTON. We know the numbers are not precise, but some numbers with some degree of exactness are better than no numbers. I want to commend the Clinton Administration for focusing attention in this area. I don't do that very often, but in this case I think it is deserved.

We will be doing follow-up questions. All members of all subcommittees will have the requisite amount of time to present opening statements for the record and written questions, and we would hope when we get those to you and your staffs that you would reply in an expeditious fashion.

Does anybody else have a final statement?

The hearing is adjourned.

[Whereupon, at 12:15 p.m., the subcommittees were adjourned.]

[Additional material submitted for the record follows:]

DEPARTMENT OF HEALTH & HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

June 23, 1998

The Honorable JOE BARTON, *Chairman*
Subcommittee on Oversight and Investigations,
Commerce Committee
U.S. House of Representatives
2125 Rayburn House Office Building
Washington, D.C. 20515

DEAR CHAIRMAN BARTON: Attached are responses for the record to questions posed by Representative Norwood in follow up to the April 24 hearing before the Committee on Commerce, Subcommittee on Oversight and Investigations, on the Fiscal Year 1997 Chief Financial Officer Audit of the Health Care Financing Administration.

I am forwarding a copy of these answers to Representative Norwood.

Sincerely,

NANCY-ANN MIN DEPARLE
Administrator

Enclosures

MATERIALS FOR THE RECORD

These are HCFA's responses to questions Rep. Norwood submitted in follow-up to the hearing.

Correct Coding Initiative

Question 1) Does HCFA plan on addressing the lack of information provided to physicians via the carriers in regard to the CCI?

Response: We make our Correct Coding Initiative edits and the underlying coverage policy on which they are based available for review by anyone. Physicians may obtain CCI edits by calling the National Technical Information Service at 1-800-553-6847 and asking to purchase the "National Correct Coding Policy Manual for Part B Medicare Carriers." They may obtain the whole package of edits or individual CPT chapters that pertain to their own practice.

Question 2) HCFA claims to have disseminated the requirements of the CCI to providers, but physicians offer a contrary perspective. How does HCFA account for this?

Response: Information on CCI edit availability was sent to each physician as part of the Medicare participation request in 1995. The AMA was and continues to be part of the review Process before the edits are implemented. Physicians may obtain CCI edits through the National Technical Information Service by calling 1-800-553-6847 and asking to purchase the "National Correct Coding Policy Manual for Part B Medicare Carriers." They may obtain the whole package of edits or individual CPT chapters that pertain to their own practice.

Question 3) How does HCFA plan to address the concerns of providers who make honest mistakes?

Response: Most physicians are honest and conscientious, but we must have zero tolerance for waste, fraud and abuse. If physicians do make honest errors, we do want to find those errors, preferably before we make payment. If we find errors after we make payment, make no mistake about it, we do want the money back. But we are not looking to put anyone in jail for honest mistakes, and we are not going to refer physicians to the Inspector General for occasional errors. We have to believe there is some level of fraudulent intent before we make any referrals for further investigation.

Question 4) How is HCFA addressing the local carriers unwilling to properly educate providers?

Response: Our contractors conduct regular training sessions and refresher courses for providers and billing staff that providers hire. Bulletins are mailed out quarterly to physicians about any change. We also work with provider groups, such as the AMA, which conduct their own training and provide other education on proper billing and documentation.

Evaluation & Management Documentation Guidelines

Question 1) Will HCFA make efforts to conduct uniform training of physicians once the E&M guidelines have been revised?

Response: On April 24, 1998, I sent a letter to the AMA (copy attached) indicating confidence that by working together we can revise Documentation Guidelines so they meet our needs to assure that Medicare payments are appropriate without im-

posing undue burden on physicians. We will work with the AMA and other physician groups to educate physicians and their billing staff on how to use these guidelines. We all want these guidelines to work so that there is consistency across the country, so we can promote high quality care and so we can help physicians avoid honest billing errors.

Question 2) It is important that all physician groups receive the same message on the use of the E&M guidelines. How will HCFA accomplish this?

Response: We will work with the AMA and other physician groups to educate physicians and their billing staff on how to use these guidelines.

Question 3) In order to receive payment, physicians are being held to a high standard based on the manner in which they document. Will HCFA hold those who review and audit physicians to the same standards?

Response: Reviewers and auditors are held to the same high standard, and in fact must use the very same documentation guidelines in conducting their reviews and audits.

Question 4) Is HCFA taking into account the need for uniformity in creating and utilizing a uniform educational program to train physicians, reviewers and auditors regarding the E&M guidelines?

Response: We recognize the need for uniformity in training physicians, reviewers and auditors in use of the guidelines, since the guidelines are themselves designed to promote uniformity in documentation requirements, reviews and audits. We most definitely will take this into account as we work with our carriers, the AMA and other physician groups to educate auditors, reviewers, physicians, and their billing staff on how to use the guidelines.

Carrier Variability

Question 1) Individual carrier interpretation is expected to a degree. Is HCFA doing anything to create more uniformity in the way its policies are interpreted at the carrier level?

Response: HCFA has been working with the Carrier Medical Directors to promote more uniformity and consistency in the interpretation of local medical review policies. The Carrier Medical Directors meet regularly to discuss medical policies and how they are being applied in their area. Additionally, the Carrier Medical Directors have developed a number of "templates" which serve as a uniform base for developing local policy. HCFA is also developing a database which provides contractors and HCFA ready access to local medical review policies in effect at each contractor. This database will further encourage Medicare carriers to share their local medical review policies in order to promote uniformity among carriers who may have or may be developing a similar policy.

Question 2) Are there efforts underway to coordinate carrier interpretation of HCFA policies?

Response: We realize that there is a need to create greater consistency in coverage among the carriers. HCFA fosters greater consistency by prompting carriers to coordinate their local policies. We also now plan to place a greater reliance on national coverage decisions. We are working to refine the national coverage process to provide for more public participation from medical specialists, health industry representatives, and other interested parties.

Question 3) When a carrier's interpretation of policy is contrary to a HCFA rule, why doesn't HCFA require the regional office to suspend the carrier ruling during an investigation and determination period?

Response: The HCFA manual instructions require that local medical review policy be clear, concise, and not restrict or conflict with national policy. If a carrier's interpretation of policy is possibly contrary to a HCFA rule, an investigation to determine whether it is in fact contrary to a HCFA rule is necessary before suspension of carrier rulings.

Question 4) Why has HCFA not addressed the wide variation in regional carrier interpretation of the rules and regulations in the Medicare Carrier Manual?

Response: As you know, when Medicare was enacted 33 years ago, Congress sought to strike a balance between local medical decision making and practice, and national policy. We have continued to try to maintain this balance. HCFA fosters greater consistency by working with Carrier Medical Directors to coordinate and share their local policies.

Question 5) How often are negative provider audits reversed in appeals?

Response: Audits are conducted for Part A providers, such as hospitals and home health agencies. Of 59,689 Part A appeals completed through the contractor appeal process in FY 1997, 30 percent of were decided in provider's favor. Of the 12,465 appeals completed by independent Administrative Law Judges, 72% were decided in the appellant's favor.

Medical reviews are conducted for Part B providers, such as physicians and equipment suppliers. Of 3,337,592 Part B appeals completed by Part B contractors in FY 1997, 70 percent were decided in provider's favor at the first level of review. Of 86,898 appeals completed at a second level of carrier appeal, 45 percent were decided in the appellant's favor. Of 4,701 appeals completed at the independent Administrative Law Judge level, 51 percent were decided in the appellant's favor.

Question 6) How often are appeals of audits reversed because of inappropriate interpretations or actions by carriers?

Response: Administrative Law Judges who hear appeals of carrier decisions generally are not bound by the manuals and instructions we issue to our carriers. They are bound by statute, regulation, HCFA rulings, and National Coverage determinations.

About 54 percent of administrative Law Judge reversals of carrier appeal decisions are due to judges reaching a different conclusion than the carrier. Another 13 percent of reversals are due to judges changing the reimbursement methodology used by the contractor; 11 percent of reversals are due to introduction of new evidence; in 9 percent of reversals the judge's ruling contradicts contractor policy; and in 7 percent of reversals the judge's ruling contradicts Medicare policy.

Question 7) HCFA is supposed to utilize peer review. How often are nurses or non-specialists used to conduct reviews under the guise of peer review?

Response: Nurses and non-specialists are not permitted to deny any claims subject to peer review. They do perform the initial screen of all claims subject to the peer review process. But any problem claims they identify are reviewed by at least two physicians prior to denial.

Attachment

DEPARTMENT OF HEALTH & HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

April 24, 1998

Percy Wooton, M.D.

President

American Medical Association

515 North State Street

Chicago, Illinois 60610

DEAR DR. WOOTON: I am writing to you about the Documentation Guidelines for Evaluation and Management Services (E/M), because I continue to hear physicians express concerns about them. I thought it would be helpful to provide you with the Health Care Financing Administration's (HCFA's) views on the Guidelines, the process for improving them, and the increased emphasis on accurate billing and proper documentation. Understandably, physicians are reacting to flaws in the Documentation Guidelines that we are committed to fix. Also, many physicians fear they will be unjustifiably targeted for fraud and abuse investigations as a result of simple coding errors. I want to do what I can to allay those fears.

As stewards of the Medicare program, HCFA must be sure the payments we make on behalf of our beneficiaries are for medically necessary and appropriate services, and that the services have been accurately reported. Our FY 1997 CFO Audit, which was released April 24, indicates that while we are making progress in reducing inappropriate payments, we still have much work to do, particularly in the area of ensuring documentation for physician claims is adequate. Inadequate or no documentation is the principal cause of the improper payments identified in the CFO audit report.

HCFA needs to be confident that Medicare carriers are reviewing medical records in a consistent manner. Physicians need assurances that they are billing appropriately and have adequate documentation in the event of an audit. A workable version of the Documentation Guidelines is an essential tool for both physicians and our carriers. Further, improving program integrity serves the interest of Medicare, its beneficiaries, and its providers, including physicians.

I have heard that physicians believe the 1997 Documentation Guidelines that the American Medical Association (AMA) and HCFA developed together are too complex and burdensome. The most troubling concern is that some physicians believe the new Guidelines will divert too much physician time and attention from patient care to paperwork. I believe we can and must work together to improve the Guidelines so they do not impose requirements in excess of those associated with clinically appropriate medical record-keeping practices.

I understand that the written comments you received in mid-March contained a number of thoughtful suggestions. I have asked Robert A. Berenson, M.D., the new director of HCFA's Center for Health Plans and Providers, to participate in your "fly

in" meeting today. We look forward to discussions about implementation issues, as well as the content of the Guidelines themselves.

In December 1997, HCFA agreed to your request that carriers use both the 1995 and 1997 versions of the Documentation Guidelines to evaluate claims until July 1, 1998. When we set that July 1 date, neither the AMA nor HCFA fully understood the magnitude of the problems with the 1997 Guidelines. I find it is unrealistic to expect that the revisions can be completed by that date and it is clear that an additional period is needed for testing the Guidelines as well as for education of physicians and carriers.

Therefore, I am directing carriers to continue to use both the 1995 and 1997 Guidelines, whichever is more advantageous to the physician, until the revisions have been completed and there has been an adequate period of time for testing and education. Since there is still uncertainty about how quickly that work can be done, I think it is premature to set an implementation date now. Dr. Berenson and his staff will report to me in the early fall on the status of the revision efforts and the projected schedule for testing, refinement, and physician education. I anticipate using that information to set a final date for implementation of the revised Guidelines that will allow ample time for completion of the pre-implementation activities.

We believe the final product will be strengthened by the broad physician participation in the revision process. Working together, we can make the Guidelines easier to understand and we can sharpen the focus so that only documentation directly related to the care provided is required.

Let me turn to the broader issue of the emphasis on fraud and abuse, particularly the provisions in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) regarding sanctions for coding errors. Civil monetary penalties may now be assessed for coding that the person knows, or should know, will result in greater payments than appropriate. However, the statute is very clear that there must be a pattern or practice of such behavior.

I want to assure you that physicians will not be punished for honest mistakes and we will not make referrals to the Office of the Inspector General for occasional errors. To be certain there is no misunderstanding about this, I have asked my staff to issue an instruction to the carriers reminding them of our long standing policy that referrals are to be made to the Office of the Inspector General for possible sanctions only after the carrier determines the situation was not caused by error and there is evidence of intentional improper billing practices. We have to believe there is some level of fraudulent intent before we make any referrals. Sanctions are intended for physicians who act in "deliberate ignorance" or with "reckless disregard" of the truth or falsity of information. For criminal penalties, the standard is that the provider had "knowing and willful" intent to defraud the government.

We are at a critical juncture in the development of the Documentation Guidelines. I am confident that by working together we can develop revised Documentation Guidelines that will meet our needs to assure that Medicare payments are appropriate without imposing undue burden on physicians. I hope your meeting is a productive one that will move us closer to that goal.

Sincerely,

NANCY-ANN MIN DEPARLE

Administrator

QUESTIONS FOR THE INSPECTOR GENERAL OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

QUESTIONS FROM THE HONORABLE STEVE HORN

Health Insurance Portability and Accountability Act

Question: I understand that the Health Insurance Portability and Accountability Act allows the Inspector General's office to be reimbursed for the cost of investigations in some cases. Has your office received reimbursement under the Act? If so, how much has your office received and what circumstances led to the reimbursement? Has this reimbursement authority assisted in your efforts to combat waste and abuse?

Answer: In Fiscal Year 1997, we received reimbursement of \$526,899 for the costs of health care related investigations. We do not have a total figure thus far in Fiscal Year 1998, but expect the amount to be similar to last year's reimbursement. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) authorizes OIG to receive and retain such funds when "ordered by a court, voluntarily agreed to by the payor, or otherwise." HIPAA also requires us to obligate such funds within one year of their deposit.

These recoveries have assisted our efforts by allowing OIG to devote resources to combating fraud and abuse in addition to those funds received under our usual budget allocation. As a matter of policy, neither we nor the Department of Justice propose the recovery of investigative costs in exchange for a settlement or criminal plea on a case. The recoveries thus allow OIG to replenish resources spent on a case only when the terms of a settlement, plea, or judgment suggest the distribution of funds for such purposes. We also receive such recoveries only after full restitution is made to the government for the fraud and, in civil cases, certain other distributions are made from the settlement or judgment proceeds.

Scope of Audit Work Performed

Question 1a: Given the requirement by OMB Bulletin 93-06 which states an audit should be performed to "obtain reasonable assurance" in regards to representation of agency's financial position, why did you not expand the scope of your audit when you found a significant weakness in contractors Medicare and Medicaid accounts receivable subsidiary ledgers?

Answer: "Reasonable assurance," as used in OMB Bulletin 93-06 and in our audit report, refers to our responsibility to do sufficient testing to determine whether the information used to prepare the agency's financial statements is reliable. In the case of Medicare accounts receivable, we reported that Medicare contractors did not maintain adequate documentation to support reported accounts receivable activity. At several contractor locations, millions of dollars in reported accounts receivable could not be reconciled to the contractors' source documents. Because of the lack of records and inconsistent application of HCFA's accounts receivable accounting policy, it was not possible to perform extended audit procedures in this area.

Question 1b: What actions are you taking to ensure that you can perform sufficient work to audit the accounts receivable?

Answer: Accounting and reporting accurately the accounts receivable data are the responsibility of HCFA management. The HCFA has developed corrective plans to address the accounts receivables deficiencies. Corrective actions include establishing teams to visit the Medicare contractors and review their accounts receivable process to ensure adequate documentation is retained. These visits are to prepare the contractors for the upcoming financial statement reviews to be performed by the OIG and its contract auditors.

Review of Internal Controls

Question 1: In regard to Medicare's reported "Other Governmental Liabilities", which totaled \$27.4 billion in 1997, you stated some contractors did not provide sufficient documentation to support claims paid, what—if any—internal controls were employed by HCFA to insure government funding was used properly and for intended purposes?

Answer: The term "Other Governmental Liabilities" is actually accounts payable. As mentioned in our report (and as shown on page 109 of the HCFA FY 1997 Financial Report), this account is comprised of five major components. The component that your question refers to is the "approved to paid claims" component, which comprised about \$2.9 billion of the \$27.4 billion of accounts payable. This component represents the sum of all claims already approved for payment for which the corresponding reimbursement has not been issued.

We obtained subsidiary ledgers for claims approved but not paid, i.e., the payment floor component of the HCFA 750 accounts payable amount for the sampled contractors. We also traced a sample of transactions from subsidiary ledgers to source documentation. We noted that 5 of the 10 sampled contractors did not maintain detailed subsidiary ledgers. However, we performed other analytical procedures to determine that the "approved to paid" claims estimate was reasonable.

For the FY 1997 financial statements, HCFA made significant improvements in estimating this liability, including the implementation of a revised estimation methodology. The HCFA is continuing to work with its contractors to ensure that they maintain supporting documentation and that the data is complete and accurate.

Question 2: What is HCFA management's role in the review of contractor's internal control processes and systems? Is this role clearly defined?

Answer: The HCFA requires that Medicare contractors perform a self-assessment and certification process of their internal controls. This process requires that the contractor certify to its compliance with the Federal Managers' Financial Integrity Act and Chief Financial Officers Act requirements by incorporating management control standards into its operations. In addition, HCFA requires its regional offices to look behind the contractor's self-assessment. Specifically, the regional office must analyze the contractor's internal controls, test them or verify the contractor's tests, and assess the result of the test performed against HCFA's expectations.

Question 3: Are these contractors required to have reviews done of their internal control, in accordance with Generally Accepted Governmental Auditing Standards? If so, did HCFA management or the Inspector General review these audits to ensure that controls were effective? If this is not done or studies are done but not reviewed, how did the Inspector General assure that contractors' internal controls were effective to reduce to a relatively low level the risk that errors or irregularities in amounts that would be material to in relation to the financial statement being audited may occur and not be detected?

Answer: Medicare contractors, acting only as agents of the Federal Government, are not subject to GAGAS requirements. However, as part of its oversight responsibilities, HCFA requires Medicare contractors to perform self-assessments of their operations, to certify to their completion, and to report to HCFA annually the results and corrective actions taken. As part of our internal control testing for the FY 1997 HCFA financial statement audit, we reviewed the results of all prior audit reports. We do not believe that HCFA's monitoring activities provide adequate assurance that benefit payment internal controls are properly established and function as designed. Our FY 1997 financial statement audit also included reviews of electronic data processing (EDP) internal controls at the Medicare contractors. These reviews, which were limited to general and application controls, identified numerous control weaknesses at the Medicare contractors, including deficiencies in entity-wide security programs and access controls.

Government auditing standards require that we plan and perform sufficient audit work to obtain reasonable assurance about whether the financial statements are free of material misstatement. Due to the inherent risk of the Medicare contractors' internal control environment and the results of the EDP internal control reviews, we did not rely on the Medicare contractors' internal controls to reduce to a relatively low level the risk that errors or irregularities in amounts may occur and not be detected. As a result, our claims sample was designed such that very little reliance could be placed on the contractors' internal controls. We performed numerous substantive tests of Medicare claims. Our detailed testing of the sampled fee-for-service claims included numerous steps to determine if the claims were paid, recorded, and reported correctly. We tested for Medicare eligibility for both the beneficiary and the provider, as well as other pricing and compliance issues.

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